General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Pontardulais Road, Fforestfach, SWANSEA, West Glamorgan, SA5 4BA

Pharmacy reference: 1086018

Type of pharmacy: Community

Date of inspection: 12/07/2024

Pharmacy context

This pharmacy is based in a supermarket on a retail park in southwest Wales. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers a range of services including provision of emergency hormonal contraception, treatment for minor ailments and a seasonal influenza vaccination service. Substance misuse services are also available.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	Some pharmacy team members have not read the standard operating procedures that underpin the services they provide. So they may not be able to demonstrate that they fully understand their role or responsibilities. And there is a risk that they may not be able to provide pharmacy services safely and effectively.
		1.6	Standard not met	The Responsible Pharmacist record is not properly maintained so it may be difficult to establish who was responsible at any given time.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy has written procedures to help make sure the team works safely. But some team members have not read them and training records for these procedures are incomplete. So there is a possibility that some team members may not fully understand their role or responsibilities. And there is a risk that they may not be able to provide services safely and effectively. The pharmacy generally keeps the records it needs to by law. But the Responsible Pharmacist record is not properly maintained, so it may be difficult to establish who was responsible for the safe and effective running of the pharmacy at any given time. The pharmacy's team members record their mistakes so they can learn from them. And they take action to help reduce the chance of similar mistakes from happening again. Pharmacy team members know how to keep people's private information safe. And they understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had systems in place to identify and manage risk, including the recording of dispensing errors and near misses. Dispensing team members explained that the pharmacist discussed near misses with them at the time they came to light. And that any patterns or trends that emerged were discussed with the whole team. Action had been taken following some near misses to reduce some risks that had been identified. For example, highlight notes had been used in the dispensary storage drawer system to alert pharmacy team members to the risks of picking errors with different strengths and forms of tramadol, different pack sizes of aspirin tablets and the look-alike, sound-alike medicines gabapentin and pregabalin. A poster describing the process to follow in the event of anaphylaxis was displayed in the consultation room.

A range of standard operating procedures (SOPs) underpinned the services provided and these had been regularly reviewed. A file in the dispensary contained paper copies of the SOPs which had been reviewed in 2018. But members of the team were unable to access the most recent electronic versions. Some pharmacy team members had signed training records to show that they had read and understood the SOPs. But five absent team members did not have a signed training record, so it was unclear whether they had been trained to follow the pharmacy's procedures. The pharmacy technician and a dispensing assistant were able to describe activities that could not take place in the absence of the responsible pharmacist. They explained that if the RP was absent, a notice was displayed at the medicines counter informing the public that certain services could not be provided. They had followed this procedure earlier that morning, as the locum pharmacist had arrived at the pharmacy an hour and a half after its usual opening time to cover a pharmacist who was unable to attend.

A formal complaints procedure was in place, and this was advertised in the pharmacy's practice leaflet, which was displayed in the retail area. Evidence of current professional indemnity insurance was available.

Most records were up to date, including private prescription, emergency supply, unlicensed specials and controlled drug records. However, the responsible pharmacist (RP) record was not well-maintained. There were two occasions in the previous fortnight on which the pharmacist had not made an entry in the RP register to show the times during which they had taken responsibility for the safe and effective running of the pharmacy. Amendments to the register were not always accompanied by a clear audit

trail. And there were occasions on which the pharmacist had not signed out of the RP register to show the time at which they had relinquished responsibility for the safe and effective running of the pharmacy. So, there was a risk that it might not be possible to identify the pharmacist in charge if something went wrong. Emergency supply records did not always include the nature of the emergency. This might make it difficult for the pharmacy team to resolve queries or investigate errors. Balances for controlled drugs were typically checked every two to four weeks.

Pharmacy team members undertook training on the information governance policy every six months and had signed confidentiality agreements. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. A privacy notice on the consultation room door signposted people to the company website for information on the way in which personal data was used and managed. The pharmacists had undertaken advanced formal safeguarding training. All other team members had undertaken in-house safeguarding training. The team had access to guidance and local safeguarding contact details via the internet.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload effectively. Pharmacy team members are appropriately trained for the jobs they do or are enrolled on a suitable training course for their role. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

A regular pharmacist manager usually worked at the pharmacy, but he had been absent for several weeks and his role was being covered by relief pharmacists employed by the company and locum pharmacists. The pharmacy was open for 12 hours a day on most days. Two pharmacists usually worked back-to-back in six hour shifts to cover this period. The pharmacy team consisted of a pharmacy technician, five dispensing assistants (DAs), a trainee DA, two medicines counter assistants and two pharmacy students. Most staff were part-time and worked for three or four six-hour shifts on different days during the week. A regular dispensing assistant was unexpectedly absent on the day of the inspection, but the team members present were able to manage the workload effectively.

Members of the pharmacy team working on the medicines counter were observed asking appropriate questions when selling over-the-counter medicines to patients. They referred to the pharmacist on several occasions for further advice on how to deal with a transaction. Pharmacy team members undertook online training provided by the organisation on operational procedures and services. They also had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. The pharmacy technician understood the revalidation process and based her continuing professional development entries on training she had undertaken and on issues she came across in her day-to-day working environment. An appraisal programme was in place, but members of the pharmacy team present had not received a performance and development review for over a year. This meant that their development needs might not always be identified or addressed. However, they understood that they could informally discuss issues with the pharmacists whenever the need arose.

There were no specific targets or incentives set for the services provided. Pharmacy team members worked well together. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists or regional manager. A whistleblowing policy was in place and posters displayed in the bathroom area advertised a confidential helpline for reporting concerns outside the organisation.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and secure. It has enough space to allow safe working and its layout protects people’s privacy.

Inspector's evidence

The pharmacy was clean, tidy and well-organised. The dispensary was small, but there was enough space to allow safe working. Some stock medicines and dispensed medicines awaiting collection were being temporarily stored on the floor, but they did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use.

A consultation room was available for private consultations and counselling and its availability was clearly advertised. It was kept locked when not in use. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy for people to access. Its team members provide services effectively. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So they might not always be able to check that medicines are still suitable, or give people advice about taking them. The pharmacy generally stores medicines appropriately and carries out some checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy team offered a range of services. These were advertised in the pharmacy's practice leaflet, which was displayed in the retail area. However, the leaflet advertised a diabetes screening service that had not been provided since 2020, which was misleading. There was wheelchair access into the pharmacy and consultation room. A hearing aid loop was available at the medicines counter. The pharmacy team signposted people requesting services they could not provide to nearby pharmacies or other providers such as the local council, which offered a needle and sharps collection service.

Dispensing staff used colour-coded baskets to ensure that medicines did not get mixed up during the dispensing process and to differentiate between different types of prescriptions. Dispensing labels were initialled by the dispenser and accuracy checker to provide an audit trail. Controlled drugs requiring safe custody were dispensed in clear bags to allow pharmacy team members to check these items at all points of the dispensing process and reduce the risk of a person receiving the wrong medicine. The team explained that the pharmacists did not perform a third check on all prescription items at the handout stage, contrary to the pharmacy's SOP. However, they gave assurances that a third check at handout was always carried out for controlled drugs requiring safe custody.

Prescriptions for dispensed medicines awaiting collection were annotated to alert team members to the fact that a CD requiring safe custody or fridge item needed to be added. Team members explained that they highlighted the date on the prescription for schedule 3 or 4 CDs awaiting collection. This was to ensure that these medicines would not be supplied past the prescription's 28-day validity period. However, two prescriptions for pregabalin and zopiclone were not marked in this way.

Prescriptions for higher-risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted, so there was a risk that counselling opportunities could be missed. The pharmacist said that she asked people prescribed high-risk medicines about relevant blood tests and dose changes but did not record these conversations. This might result in a lack of continuity of care. Pharmacy team members were aware of the risks of using medicines containing valproate during pregnancy. They were also aware of the requirement to supply valproate products in original packs. A shelf-edge sticker included a message to remind them of this. They confirmed that people prescribed valproate who met the risk criteria were counselled and provided with educational information at each time of dispensing.

A discharge medicines review service was provided, although uptake of this was low. Uptake of the common ailments service was steady. Demand for the emergency supply of prescribed medicines service and the emergency hormonal contraception (EHC) service was high, as the pharmacy was open for longer hours than local GP surgeries and opened throughout the weekend. The pharmacy provided a supervised consumption service. People using the service were allocated a section in a dedicated file

which included their prescription, claim form if supervised, notes of any messages or changes and relevant documents such as communication letters from the substance misuse agency team. The pharmacy also offered a smoking cessation service (supply only) and a seasonal influenza vaccination service. And it provided a prescription collection service from a nearby GP surgery on one day each week.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in a large, well-organised medical fridge. Maximum and minimum temperatures for the fridge were usually recorded daily, although there were occasional gaps in the records. This might make it difficult for the pharmacy to be assured that these medicines are safe and fit for purpose. Recorded temperatures were consistently within the required range. CDs were stored in two CD cabinets. Some different products and different strengths of the same product were stored closely together in baskets in the cabinets, increasing the risk of picking errors. One cabinet contained a large quantity of obsolete CDs awaiting destruction, which occupied a lot of the available space. Obsolete CDs were kept separately from usable stock to help reduce the risk of them being used.

There was some evidence to show that regular expiry date checks were carried out, although the frequency and scope of these checks were not documented. This created a risk that out-of-date medicines might be overlooked, although none were found. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received safety alerts and recalls via suppliers and its NHS email account. The pharmacy team were able to describe how they would deal with a medicine recall by contacting patients where necessary, quarantining affected stock, and returning it to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services they offer. And its team members use these in a way that protects people's privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. People prescribed methadone were provided with their doses using an automated machine which dispensed these accurately and securely. Methadone was stored in a lockable compartment of the machine during the day. The machine was cleaned and calibrated daily. Triangles were used to count loose tablets. A separate triangle was used to count loose cytotoxics to prevent cross-contamination. The pharmacy had a range of up-to-date reference sources.

All equipment was in good working order, clean and appropriately managed. Equipment and facilities were used in a way that protected the privacy and dignity of patients and the public. For example, the consultation room was used for private conversations and counselling. The pharmacy software system was protected with a password and computer screens were not visible to people using the pharmacy. Some bags of dispensed medicines were being temporarily stored in the consultation room, but no confidential information was visible.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.