General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Angel Drove, ELY, Cambridgeshire, CB7 4DJ

Pharmacy reference: 1097082

Type of pharmacy: Community

Date of inspection: 14/11/2023

Pharmacy context

This community pharmacy is at the front of a large supermarket in Ely. Its main activities are dispensing NHS prescriptions and providing advice to people about over-the-counter medicines. It also provides substance misuse treatment to some people, and it is currently providing seasonal flu vaccinations.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
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 met

Summary findings

The pharmacy has systems in place to identify and manage risks and its team members have access to written procedures to help them work safely. The pharmacy's team members understand their roles and responsibilities and they keep people's information safe. The pharmacy generally keeps the records it needs to by law. But the details for private prescriptions are not always recorded correctly and this could make it harder to handle queries in future.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to help deliver its services safely and these were reviewed regularly by the company. There was a process to make sure team members had read and understood the SOPs relevant to their roles including any updates. However, it was less clear how locum pharmacists were kept up to date about any changes to the SOPs.

The pharmacy had record sheets available to write down dispensing mistakes the team members made that were spotted before the medicines were handed out (referred to as near misses). The most recent record was from the start of November 2023 and some entries had made each month prior to this. The records contained limited information about the mistake and there was often no record kept of any next steps identified to prevent similar mistakes happening again. This could mean opportunities to learn and improve from these are missed. There was also a process to record and report mistakes which reached people (known as dispensing errors) to head office. And there was evidence that the last error had been recorded and reviewed appropriately including sharing learnings from the incident with the team. Some medicines with similar names or similar packaging had been more clearly separated and the storage areas highlighted to prevent picking errors. The pharmacy stored methotrexate and warfarin in designated areas to reduce the risk of picking errors.

Members of the team could explain what they could and couldn't do when a pharmacist was not present. When asked a member of the team was able to explain the restrictions on sales of painkillers containing codeine and would refer repeat requests to purchase these to the pharmacist. They also knew to refer requests for emergency contraception to the pharmacist. The pharmacy did not sell codeine linctus over the counter. The pharmacy had a complaints procedure and people would usually be signposted to head office if they wanted to raise a formal complaint in the event the pharmacy team members could not resolve an issue. People could also make complaints direct to head office online.

The pharmacy had current professional indemnity and public liability insurance. Records about controlled drugs (CDs) were kept and complied with legal requirements. CD running balances were kept and checked for accuracy periodically. Manufacturer's overages were recorded correctly. The stock of two CDs chosen at random agreed with the recorded balances. The pharmacy had a separate register for patient-returned CDs and there were denaturing kits available. The responsible pharmacist (RP) notice was displayed where people visiting the pharmacy could see it. It was changed at the start of the inspection to show the correct details for the RP on duty. Records about the RP were kept and were complete. Records about private prescriptions were kept electronically. Recent entries checked did not always include the correct prescriber's details or the correct date on which the prescription was written. This was pointed out to the team members who said they would make sure the correct

information was recorded in future.

There were written procedures and staff training about protecting confidentiality. The team members did annual refresher training on information governance. Sensitive information was stored out of the reach and sight of the public and confidential waste was disposed of securely. There was a data privacy notice poster displayed where people could see it. The IT system was password protected and the dispenser was using their own smartcard to access electronic prescriptions. Team members and the RP had completed safeguarding training relevant to their roles. The team understood what to do if there was a concern about the welfare of a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages its workload adequately. Team members work well together and are enrolled on the right training for their roles. And they receive additional training materials to help keep their skills and knowledge up to date. They know when to refer queries to the pharmacist, so people get the right advice and information.

Inspector's evidence

The pharmacy had not had a pharmacy manager for around four years, but some other members of the team had worked at the pharmacy for quite a few years. At the time of the inspection, the RP was a locum pharmacist and was supported by a trained dispenser and a trainee dispenser. Cover from locum dispensers was sometimes available as was assistance from staff at local branches. The pharmacy had one vacancy currently advertised. The pharmacy had been able to find pharmacist cover for all shifts so had not had to close unexpectedly. Though busy throughout, the team members coped with the workload during the inspection. And they worked closely together, discussing queries, and helping each other when needed. Team members referred queries to the RP where professional input was required.

The team members were currently up to date with routine dispensing. The trainee dispenser was being given more straightforward prescriptions to assemble and was supervised and assisted by the trained dispenser. There were some certificates displayed showing the training some of the team had completed. Those in training had time set aside during the working week to help them complete the appropriate accredited training for the roles they undertook. To help keep their skills and knowledge up to date, team members also had access to training modules provided by the company, some of which were considered mandatory. The team members were prompted about any new or mandatory training and its completion was tracked. However, the team members did not currently have any formal appraisals which could mean individual development needs might not always be identified and addressed.

The team members said they could raise issues and concerns with their area manager and there was a weekly conference call with the area manager to share information. There was also a company newsletter sent out to branches with professional updates.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally adequate for the safe provision of pharmacy services. The pharmacy is kept secure when the pharmacy is closed. And people can have a conversation with members of the pharmacy team in a private area and won't be overheard. There are some outstanding repairs due in the dispensary. And care is needed to make sure the introduction of additional IT equipment in the dispensary does not adversely impact safe ways of working.

Inspector's evidence

Overall, the premises had just about enough space to dispense and store medicines and the pharmacy was reasonably clean and tidy. However, there were several stacks of baskets with part-processed prescriptions which were taking up some of the dispensing bench space. Also, the team said the pharmacy was due to get another computer terminal installed in the dispensary imminently. This could put further pressure on the safe working space and could increase the risk of mistakes happening. Room temperatures in the premises were controllable, and levels of ventilation and lighting were appropriate for the activities undertaken. The pharmacy team members had access to rest areas and hygiene facilities in the main store.

One the dispensary drawers was broken and couldn't be moved easily to find stock. This had already been reported to the company's maintenance team but had not been fixed permanently. The pharmacy had a consultation room which was reasonably large and well kept. It had lockable storage and a computer terminal which supported its use for services. People could have a private conversation about their healthcare and access services in this room. The premises could be secured outside of opening hours. The dispensary was clearly separated from the shop area and access by the public was suitably restricted. Personal information on dispensed medicines was kept away from public view to protect people's privacy and information on computer screens could not be seen by the public.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally provided safely. The pharmacy team manages its medicines well to make sure people are supplied medicines which are safe to use. The pharmacy team members are aware of the need for extra care when supplying certain medicines which may be higher risk, including medicines containing valproate. This is so people receive the information they need to take their medicines safely.

Inspector's evidence

The pharmacy's opening hours were displayed where people could see them. The entrance doors to the supermarket were power assisted and level with the pavement and the aisles were wide enough to accommodate people with prams or wheelchairs. There was an induction hearing loop available, with instructions for people wishing to make use of this equipment. There was ample parking for people on site. And two seats near the pharmacy counter for people waiting for services. The pharmacy did not currently supply any medicines in multi-compartment compliance packs, and did not offer this routinely as a service due to lack of space to prepare the packs safely.

Dispensing carried out during the visit was being done in an orderly way. Baskets were used to keep prescriptions for different people separate. There was an audit trail on dispensed items to show who had been involved in dispensing and checking each medicine. All dispensed items were accuracy-checked by the RP and were subject to a third check just before handing out to people. Warning stickers were attached to fridge lines and some CDs to indicate they were stored separately and to check that prescriptions for the CDs were still valid. But the pharmacy didn't use a similar approach to CDs which did not require secure storage. This could increase the chance of supplying medicines beyond the valid date of the prescription and the risks were discussed with the team during the inspection. The team members understood that prescriptions for valproate needed additional care when supplying to people who might become pregnant. And they knew about the updated guidance to supply these medicines in their original packs. The stock packs available had the warning cards and alert stickers attached. When asked, the dispenser could explain the types of checks they would make with people when they supplied higher-risk medicines such as methotrexate and warfarin. And there were prompts on the patient medication record when dispensing these items to highlight the need for additional checks.

The pharmacy had ready access to injectable adrenaline if a person suffered an anaphylactic reaction to a flu vaccination. And there was information clearly displayed in the consultation room about how to deal with this type of situation and provide emergency first aid including resuscitation if needed. Sharps and clinical waste derived from this vaccination service were managed appropriately.

Medicines were obtained from licensed wholesalers and specials were obtained from specials manufacturers. Medicines were stored in dispensary drawers and on shelves in the dispensary. Medicines for dispensing were kept in appropriately labelled containers. CDs were stored securely. There was a date-checking record kept to make sure all areas of the dispensary were checked regularly. Obsolete medicines were separated from dispensing stock and disposed of through licensed waste contractors. When spot-checked, no date-expired medicines were found amongst dispensing stock. The medicines fridge temperatures were monitored and were kept within the required range for medicines

requiring refrigeration. No extemporaneous dispensing was carried out.

The pharmacy had a process to receive and act on drug recalls and safety alerts. It was notified of these by its head office and there was a system in place to make sure these were responded to.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it generally has systems in place to maintain its equipment.

Inspector's evidence

The pharmacy has sufficient fridge storage space to keep its stock of temperature-sensitive medicines. And it made sure the fridge was operating correctly. It had measuring and counting equipment of a suitable standard. Some of the glass measures were reserved for measuring specific types of medicines to prevent cross-contamination. These were reasonably clean. The pharmacy had access to online reference sources to assist with clinical checks and other services. It also had the right equipment to assist the safe disposal of medicines and sharps waste and kept these out of reach of the public. All portable electrical equipment appeared to be in good working order and testing of this was arranged by head office. The pharmacy had cordless phones so team members could make phone calls out of earshot of waiting customers if needed. The pharmacy's patient medication records and computer screens in the pharmacy could not be viewed from the shop floor.

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.