General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Wellspark, CREDITON, Devon, EX17 3PH

Pharmacy reference: 1101426

Type of pharmacy: Community

Date of inspection: 27/02/2023

Pharmacy context

The pharmacy is located within a supermarket in Crediton. It dispenses NHS and private prescriptions. It sells over-the-counter medicines and provides advice to people about minor illnesses and long-term conditions. The pharmacy offers services including flu vaccinations, the NHS New Medicine Service (NMS), the Community Pharmacy Consultation Service (CPCS).

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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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	The pharmacy does not routinely assess key risks to patient safety from its activities and services. The pharmacy has not felt the benefit of risk assessments carried out by the head office team on the impact of significant changes in the local area which led to an increased workload. Team members do not always follow the pharmacy's written procedures which state who should complete each task and how it should be done.
		1.2	Standard not met	Team members do not routinely record and review mistakes they make. This means that there is limited opportunity to learn from mistakes and prevent them from happening again in the future.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough team members to manage its workload safely. The pharmacist is regularly left to work alone in the pharmacy, which has led to mistakes being made.
		2.2	Standard not met	Pharmacy team members carry out tasks that they have not received appropriate training for. And they have not been registered on the required courses.
		2.5	Standard not met	The pharmacy team do not feel that they are listened to when they raise concerns about the pharmacy. They work under considerable pressure and stress.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Expired medicines are not routinely removed from stock and there is a risk that these may be supplied to people. The pharmacy does not monitor the temperature of its fridge meaning that it may not be aware when cold-chain medicines are stored outside the required temperature range.
		4.4	Standard not met	The pharmacy does not have a robust system in place to ensure that recalls of

Principle	Principle finding	Exception standard reference	Notable practice	Why
				defective medicines are actioned appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy does not routinely assess key risks to patient safety from its activities and services. The pharmacy has not felt the benefit of risk assessments carried out by the head office team on the impact of significant changes in the local area which led to an increased workload. Team members do not routinely record and review mistakes they make. This means that there is limited opportunity to learn from mistakes and prevent them from happening again in the future. Team members do not always follow the pharmacy's written procedures which state who should complete each task and how it should be done. But the pharmacy responds appropriately when it receives feedback. And team members understand their role in ensuring vulnerable people are protected. The pharmacy keeps people's private information safe.

Inspector's evidence

The team members present did not have access to the tools required to complete activities to ensure the safe and efficient running of the pharmacy. They were unaware of any risk assessments of the services provided by the pharmacy. A new GP practice had recently opened close to the pharmacy. This, along with several new housing developments in the town, had led to a 23% increase in items over the last year. But there had been no adjustments made to staffing levels or risk assessments carried out on the impact of this uplift.

The pharmacy had a paper log on which to record any mistakes they made which were picked up during the final accuracy check, known as near-misses. But reporting had stopped when the previous manager had left. The branch had been the subject of an in-house audit in February 2023 which had identified that reporting of errors was low. Since the audit, four near-misses had been recorded. But the MCA who was dispensing on the day of the inspection, freely admitted that there were many more errors. And that some of these errors had reached the patient. No recent written reviews of errors were seen and the pharmacy team were not aware that any had been recorded.

The pharmacy procedures said that errors that reached the patient should be reported on the 'Communications Centre'. But none of the team members had log in details. Therefore errors were not reported. A dispensing error had occurred over the previous weekend which had been rectified with the patient but the team had been unable to report it. A pharmacist from a nearby branch, who had stepped up to cover the regional manager's leave, was in the branch during the inspection. He said that when team members had no access to the Communications Centre, all errors should be reported to the regional manager so that he could report them. But he was unaware of the recent error and the team members did not know that they should have alerted him to the error.

The pharmacy did have some written SOPs and the team members had read them. But updates and new SOPs were released on the 'Communications Centre', which the team members had no access to. So they did not receive updates from the company about safety issues. Alerts and recalls were received on the communications hub and by NHS email. The team members did not have NHS email addresses and could not access the pharmacy's shared NHS email account. The regional manager said that the supermarket administration team should alert the pharmacy to alerts and recalls it received.

The pharmacy had a documented procedure in place for handling complaints or feedback from people.

There was information for people displayed in the retail area about how to provide the pharmacy with feedback. Any complaints were passed straight to the RP to deal with. The RP said that the number of complaints had increased recently. And that the team sometimes felt intimidated and threatened.

The pharmacy kept a record of who had acted as the RP each day. The correct RP notice was prominently displayed. Controlled drug (CD) registers were in order. Balance checks had previously been completed by the dispenser who had left. And there was currently no one trained in the pharmacy to complete the checks apart from the pharmacist, who was too busy to do it. A random balance check was accurate. Patient returned CDs were recorded in a separate register and were destroyed promptly. Records of private prescriptions were held on the patient medication record system. The pharmacy team thought that there was a private prescription book, but it could not be located. The pharmacy kept records of the receipt and supplies of unlicensed medicines ('specials'). Certificates of conformity were stored with all required details completed. Public liability and professional indemnity insurances were in place.

All team members had completed training on information governance and general data protection regulations. Patient data and confidential waste were dealt with in a secure manner to protect privacy and no confidential information was visible from customer areas. Team members ensured that they used their own NHS smart cards.

All staff were trained to an appropriate level on safeguarding. The RP had completed the Centre for Postgraduate Pharmacy Education (CPPE) level 2 safeguarding training. Local contacts for the referral of concerns were available. Team members were aware of signs of concerns requiring escalation.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not have enough team members to manage its workload safely. Team members carry out tasks that they have not received appropriate training for. And they have not been registered on the required training courses. The pharmacy team do not feel that they are listened to when they raise concerns about the pharmacy. They work under considerable pressure and stress.

Inspector's evidence

The pharmacy did not have enough staff to safely manage its workload. The previous pharmacist manager had left in November 2022. The responsible pharmacist (RP) on the day of the inspection was a locum. And a full-time dispenser had resigned two weeks ago. There was currently no trained dispenser. There were three part-time trainee medicines counter assistants who covered around two-thirds of the pharmacy's opening hours (100 per week) between them. Two of the trainee MCAs assisted with dispensing despite not being enrolled on a training course.

On the day of the inspection, the RP was a locum who worked in the pharmacy two days each week. There was a part-time trainee MCA. The interim regional manager role was also at the pharmacy trying to catch up on administrative tasks following an internal audit. The pharmacy was open for 100 hours each week. Whilst there was sufficient pharmacist cover provided by two other locum pharmacists, there was insufficient numbers of support staff. There were two other trainee MCAs who worked part time. The regional manager said that the pharmacy was allocated 104 support staff hours but the pharmacy currently only employed support staff for 64 hours. This left a shortfall of 40 hours when the pharmacist worked alone.

The three members of support staff were all trainee MCAs. Two of them had been dispensing prescriptions for over six months but were not registered on a training programme. They had not received any official training to dispense. They were expected to cover the medicines counter and dispense prescriptions when they could. The MCA that was working during the inspection said that she felt very under pressure and didn't feel that the situation was safe. Prescriptions were rarely ready when people arrived to collect them. The pharmacy team were behind on many of the required tasks, focussing on dispensing for people who arrived at the pharmacy.

The trainee MCA had completed the majority of the healthcare assistant's course. But she had been waiting for around six months for a manager to complete a 'core testament statement' to confirm competency. This would then release the final assessment. She was unaware of the additional in-house learning, shown to her during the inspection by the interim regional manager, that she would need to complete on the 'Communications Channel' before she could be registered for the dispenser's course. Due to the lack of access to the 'Communications Channel', she did not have access to the company specific training programmes, including 'Pharmacy safe and legal'. Team members were very willing to do the required training but could not access the right channels to get enrolled. In general, there was a lack of support and communication to the team around training. And team members said that there was no time to complete training during working hours.

Due to the lack of staff and the long opening hours, the pharmacy regularly had to close for two separate hours so that the different pharmacists could have a mental break. The MCA knew what tasks

could not be completed in the absence of an RP. The pharmacy team had raised concerns to the regional manager and the store manager about the stressful working conditions but they did not feel that they had been addressed. The pharmacy was currently advertising for additional team members, but the pharmacy team did not feel that the advertised hours reflected what was required for the safe running of the pharmacy. They had suggested to the store manager what working patterns may attract candidates, for instance not solely evenings and weekends, but this had been rejected.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. The pharmacy has a private room where people can have conversations with members of the pharmacy team. The pharmacy is adequately secured to prevent unauthorised access.

Inspector's evidence

The pharmacy was located at the rear of a supermarket in Crediton. A healthcare counter led to a small dispensary. A consultation room was available and had health-related posters and information displayed. The room was not locked when not in use but no confidential information or medicines were stored in the room. The dispensary stock was generally well organised and tidy. Most of the stock was stored in pull-out drawers. The most commonly prescribed medicines, larger items, creams and liquids were stored on shelves. There were dedicated areas for dispensing and checking. This gave the pharmacist the required space and reduced distractions. Prescriptions awaiting collection were stored in a retrieval system.

Team members cleaned the pharmacy every day. The healthcare counter had clear Perspex screens fitted to protect team members from COVID-19. Hand sanitiser was available throughout the pharmacy. The lighting and temperature of the pharmacy were appropriate for the storage and preparation of medicines.

One of the pull-out storage drawers was broken but otherwise the storage unit was in good condition. The dispensary sink was clean. But the hot tap was not secured to the sink and was leaking.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy cannot always show that it provides its services safely. Expired medicines are not routinely removed from stock and there is a risk that these may be supplied to people. The pharmacy does not have a robust system in place to ensure that recalls of defective medicines are actioned. The pharmacy does not monitor the temperature of its fridge meaning that it may not be aware when cold-chain medicines are stored outside the required temperature range. The pharmacy is accessible and advertises its services appropriately. Pharmacy team members ensure that people receiving high-risk medicines are provided with appropriate advice to help them take their medicines safely.

Inspector's evidence

The pharmacy was open from 8am to 11pm on a Monday, 7am to 11pm, Tuesday to Friday, 7am to 10pm on a Saturday and from 10am to 4pm on a Sunday. It was in a large supermarket which had level access and automatic doors. There were wheelchairs available at the entrance to the supermarket. And the supermarket had a large carpark. The pharmacy could produce large print labels if people had poor eyesight. A range of health-related posters and leaflets were displayed and advertised details of services offered both in store and locally. The pharmacy team explained that if a person requested a service not offered by the pharmacy at the time, they referred them to other nearby pharmacies or providers, calling ahead to ensure the service could be provided there. Up-to-date signposting resources and details of local support agencies were accessed online.

The pharmacy had a clear workflow to ensure prescriptions were dispensed safely. Team members used baskets to store dispensed prescriptions and medicines to prevent transfer between patients as well as to organise the workload. There were designated areas to dispense and accuracy check prescriptions. Team members initialled the labels of medicines when they dispensed and checked them.

Coloured stickers were used to highlight fridge items and CDs in schedules two and three. Prescriptions containing high-risk medicines or paediatric medicines were also highlighted with stickers. The RP described that team members checked if patients receiving high-risk medicines such as lithium, warfarin and methotrexate had had blood tests recently and gave additional advice as needed. Stickers were used to highlight prescriptions that had been identified by the RP as requiring additional counselling by a pharmacist.

The pharmacy provided substance misuse services to a small number of people. The RP described that they liaised with the prescriber or the key worker to report erratic pick-ups and to discuss any other concerns about users of the service.

The pharmacy offered some additional services including flu vaccinations. The patient group directions to cover the NHS and the private service were available and had been signed. The RP had completed training on injection techniques and anaphylaxis and resuscitation within the last two years. The pharmacy was registered to receive referrals as part of the CPCS and but received few referrals. As mentioned in principle 1, the pharmacy team did not have any access to NHS mail so sporadically checked Pharmoutcomes to see if there were referrals waiting for them to action. This inevitably meant that some were missed. The RP contacted people by telephone to discuss how they were getting on

with any new medicines they were prescribed as part of the NHS New Medicines Service.

The RP was aware of the risks of people becoming pregnant whilst taking sodium valproate. They knew to speak to people about the Pregnancy Prevention Programme (PPP). Records were made on the PMR of any conversations of this type. The pharmacy had stickers for staff to apply to valproate medicines dispensed out of original containers to highlight the risks of pregnancy to people receiving prescriptions for valproate. The pharmacy had the information booklets and cards to hand out as appropriate.

The dispensary stock was generally arranged alphabetically on shelves and in drawers. The pharmacy team were behind with date checking and multiple date expired medicines were found by the inspector in one area of shelving alone. They included:
Phenytoin 100mg tablets expired 1/2022
Nortriptyline 25mg tablets expired 12/2022
Tenif 50mg/20mg capsules expired 12/2022
Pantoprazole 40mg tablets expired 02/2023
Tamiflu 30mg capsules expired 01/2023
There were also several medicines which had been dispensed and returned to the shelves in white boxes. They contained no batch numbers or expiry days.

Prescriptions containing owings were appropriately managed and the prescription was kept with the balance until it was collected. The pharmacy was experiencing some shortages of medicines which reflected the nationwide situation. They placed orders for owed medicines each day. Stock was obtained from reputable sources.

As mentioned in principle one, the pharmacy did not have a robust system in place to receive recalls and alerts due to the lack of access to NHS mail and the 'Communications hub'. They relied on the store admin team to inform them of any recalls and alerts received through the store system. But as seen during the inspection, this was neither reliable nor prompt. Patient returned medication was dealt with appropriately.

The dispensary fridge was clean, tidy and generally well organised, although there were some food items stored amongst the medicines. The pharmacy team did not routinely monitor the temperature of the fridge. This was a daily task set on the 'Communications Centre' but as the team had no access to the system, they could not record the temperatures.

The pharmacy stored CDs in accordance with legal requirements in approved cabinets. Denaturing kits were available for safe destruction of CDs. Expired CDs were clearly marked and segregated in the cabinet. Patient returned CDs were recorded in a register and destroyed in the presence of a witness and two signatures were recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses appropriate equipment and facilities to provide its services. However, the pharmacy would benefit from an additional computer terminal. The pharmacy keeps its equipment clean, tidy and well-maintained. The positioning of the equipment protects people's private information.

Inspector's evidence

The pharmacy only had one computer terminal which could be used to access the PMR and label prescriptions. This meant that if the MCA needed to check a person's record to find their prescription, the RP who was labelling and clinically checking was interrupted. The team said that an additional terminal would speed up service and reduce the risk of errors.

The pharmacy had up-to-date written reference resources available including the British National Formulary (BNF). Team members had access to the internet to support them in obtaining current information. The pharmacy's computer system was password protected. And each team member used their own NHS Smartcard. Information displayed on computer monitors was suitably protected from unauthorised view.

The pharmacy had clean equipment available for counting and measuring medicines. It highlighted equipment for measuring and counting higher-risk medicines. This helped to reduce any risk of cross contamination. A range of consumables and equipment to support the flu vaccination service was available within the consultation room. Electrical equipment was visibly free of wear and tear and in good working order.

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.