

Registered pharmacy inspection report

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

Pharmacy reference: 1101426

Type of pharmacy: Community

Date of inspection: 09/10/2023

Pharmacy context

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

Overall inspection outcome

✓ **Standards met**

Required Action: None

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 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 provides its services safely and effectively. It has systems in place to identify and manage the risks associated with its services. Team members usually record any mistakes they make and review them to identify the cause. The pharmacy team then makes the necessary changes to stop mistakes from happening again. The pharmacy has written procedures in place to help ensure that its team members work safely. The pharmacy asks people for their feedback on its services and responds appropriately. It has the required insurance in place to cover its services. And it generally keeps all the records required by law. The pharmacy keeps people's private information safe. Pharmacy team members know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had processes in place to identify, manage and reduce its risks. It had standard operating procedures (SOPs) which reflected the way the team worked. The SOPs were printed and stored in a folder but could also be accessed online. Each team member had a record of the SOPs that they had read. The SOPs were reviewed regularly by the superintendent pharmacist. The pharmacy team could describe the activities that could not be undertaken in the absence of the responsible pharmacist (RP). The pharmacy had risk assessments in place to cover its activities. And it had a written business continuity plan.

Pharmacy team members recorded mistakes they made which were picked up during the final accuracy check, known as near misses, on a paper log. There was no written evidence of near misses being reviewed. But the RP said that they were discussed as a team when they occurred and action taken to prevent a reoccurrence. The team placed alert stickers on the shelf-edge of items that had been dispensed incorrectly. Medicines that looked or sounded alike were separated to reduce the risk of the incorrect one being selected.

Dispensing errors that reached the patient were not routinely reported or the cause analysed. Items returned by people were placed in a box with a copy of the prescription. But none of the pharmacy team had access to the internal communications centre so they were unable to complete incident reports. The manager of a nearby branch, who arrived during the inspection to support, said that when the team were unable to report errors, they should contact the regional manager, who would complete the report on their behalf. But the pharmacy team were unaware of this process. The inspector spoke to the regional manager following the inspection and he provided assurances that all team members and locums would be made aware of the need to inform either him or the manager from the nearby branch of any errors. He also said that two permanent pharmacists had been recruited and would have access to the required systems.

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 or the manager to deal with. The manager made sure to pass any compliments received to the team. Public liability and professional indemnity insurances were in place.

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 generally in order. There was a box of generic methylphenidate in the CD cabinet that did not have a register. An invoice for it was found from approximately four weeks earlier which had a note from a locum pharmacist saying that it had not been entered as there was no register for it. But no one had rectified this. The RP created a new register during the inspection and made an appropriate entry retrospectively. The inspector advised them to report it to the controlled drugs accountable officer. CD balance checks were completed regularly. A random balance check was accurate. Patient returned CDs were recorded in a separate register.

Records of private prescriptions were maintained on the patient medication record (PMR) system and contained all legally required details. But there were several instances where the incorrect prescriber was recorded. The pharmacy kept records of the receipt and supplies of unlicensed medicines ('specials'). Certificates of conformity were stored with all required details completed.

All team members completed yearly 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. Verbal consent was obtained before summary care records were accessed and a record of access was made on the person's patient medication record (PMR).

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 and knew what action to take.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy employs enough people to manage its workload. Team members are generally trained to deliver their roles although some have not been registered on an appropriate training course. Team members keep their skills up to date by completing regular learning activities. They are confident to suggest and make changes to the way they work to improve their services. Team members communicate effectively. And they work well together to deliver the pharmacy's services.

Inspector's evidence

On arrival, the RP was a locum pharmacist who worked in the branch two days each week. There were no other trained pharmacy staff present. A member of the store team was working on the medicines counter and had been since approximately April 2023. She had not received any pharmacy training but had read the SOPs. There were two trainee dispensers, one of whom was on annual leave and the other was on day off. There were also two trainee medicines counter assistants (MCAs). The employed pharmacist from a nearby branch visited the pharmacy every few weeks to complete managerial tasks and arrived during the inspection.

The pharmacy team seemed to be coping well with the workload and dispensing was up to date. Team members worked well together and supported each other. The team member working on the healthcare counter referred anyone asking for advice to the RP, who was seen to be supervising all activity on the counter.

Team members were given allocated time during working hours to learn. Trainees were supported through their courses. Each team member kept a record of progress through courses. They had access to a range of learning materials.

The team were able to discuss concerns and give feedback to the regional manager but felt that these discussions did not always result in changes. For example, the team had raised concerns around the pharmacy only having computer terminal, which led to frequent distractions during the dispensing process as the counter staff needed to check the progress of prescriptions for people coming to collect. But no additional terminal had been approved. Team members were aware of the internal escalation process for concerns and a whistleblowing policy was in place.

The RP was not set any specific targets. They used their clinical judgement and ensured all services provided by the pharmacy were appropriate for the person.

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 locked when not in use and 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. Clear Perspex screens which were installed during the COVID-19 pandemic to protect team members had recently been removed. The lighting and temperature of the pharmacy were appropriate for the storage and preparation of medicines.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy team make sure that people with different needs can access its various services. The pharmacy supplies medicines safely to people with appropriate advice to ensure they are used correctly. Team members take steps to identify people prescribed high-risk medicines to ensure that they are given additional information. The pharmacy obtains its medicines from reputable suppliers. It stores them securely and makes regular checks to ensure that they are still suitable for supply. The pharmacy accepts unwanted medicines and disposes of them appropriately.

Inspector's evidence

The pharmacy had step-free access and was wheelchair accessible. The supermarket had an automatic door and there were wheelchairs available for people to use if needed. The pharmacy provided additional support for people with disabilities, such as producing large print labels. The pharmacy displayed some health-related posters in the waiting area. The pharmacy team could print information from the internet if required.

The pharmacy used its consultation room to allow the pharmacist to have private conversations with people. The pharmacy offered a limited range of additional services. This included receiving referrals as part of the Community Pharmacy Consultation Service. The pharmacy supplied opioid replacement medicines to a small number of people. The RP liaised with the drug and alcohol team and the person's key worker in the event of any concerns or issues. The pharmacy offered the NHS New Medicines Service. Pharmacists contacted people prescribed new medicines to check how they were getting on and to offer any advice needed. Team members explained that if a person requested a service not offered by the pharmacy, 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 flow 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 prescriptions containing fridge items and CDs in schedules 2 and 3. The RP described that they checked if patients receiving lithium, warfarin and methotrexate had had blood tests recently, and gave additional advice as needed. And they made records of this advice on the PMR.

The pharmacy team was aware of the risks associated with people becoming pregnant whilst taking sodium valproate as part of the Pregnancy Prevention Programme (PPP). The pharmacy team took care not to apply labels over the warning cards on the boxes of valproate products when dispensing. 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 RP had regular conversations with the people at risk who were prescribed valproate to ensure they were on adequate contraception. And records were made on the PMR.

Pharmacy (P) medicines were stored behind the medicines counter. The dispensary stock was generally arranged alphabetically in drawers and was well organised. The pharmacy team regularly checked the expiry dates of medicines stock. They kept records of these checks. Spot checks revealed no date-expired medicines or mixed batches. Prescriptions containing omissions were appropriately managed and the prescription was kept with the balance until it was collected. The pharmacy placed orders several times throughout the day and tried to keep people informed of the estimated date that owing medicines would be available. Stock was obtained from reputable sources. Records of recalls and alerts were actioned promptly. Relevant alerts were printed and stored with any quarantined stock.

The pharmacy stored its CDs in accordance with legal requirements in an approved cabinet. A denaturing kit was available so that any CDs awaiting destruction could be processed. 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. The dispensary fridge was clean, tidy and well organised and records of temperatures were maintained. The maximum and minimum temperatures were within the required range.

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 felt 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.