General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Ware Road, HERTFORD, Hertfordshire, SG14 1QA

Pharmacy reference: 1108488

Type of pharmacy: Community

Date of inspection: 23/01/2020

Pharmacy context

The pharmacy is within a supermarket and it is well signposted from the main entrance. It provides NHS and private prescription dispensing. It is open for 100 hours each week, but the supermarket is open for longer. The pharmacy supplies a flu vaccination service and supplies medicines in multi-compartment compliance packs to some people.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	Whilst the pharmacy is up to date with routine tasks and dispensing, this is only because one member of the team is working excessive hours. This is not sustainable.
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

Members of the pharmacy team work to professional standards and try to identify and manage risks. They are clear about their roles and responsibilities. They log any mistakes they make during the pharmacy processes. And they take steps to avoid problems being repeated. The pharmacy keeps its records up to date which show that it is providing safe services. It manages and protects information well and it tells people how their private information will be used. The team members also understand how they can help to protect the welfare of vulnerable people. The lack of regular staff has increased the reliance on a single member of staff, which increases the risk of poor service for customers.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were issued by the company. The SOPs covered the services that were offered by the pharmacy. A sample of SOPs was chosen at random and these had been reviewed within the last two years. They were signed by the pharmacy's team members to indicate they had been read. The written procedures said the team members should log any mistakes in the process in order to learn from them. They were regularly logged, and similar sounding or looking medicines had been moved on the shelves to try to prevent picking errors. The largest risk to the pharmacy's safety was the reliance on one member of permanent staff in the dispensary. Although recruitment was on-going it appeared that this and the retention of staff was an issue.

The pharmacy conspicuously displayed the responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice when needed.

The annual NHS customer questionnaire was displayed on the NHS website and highlighted the length of time taken to dispense prescriptions and the cleanliness of the pharmacy. Following this the pharmacy had been cleaned, and was found to be generally clean at the time of the inspection. However, the length of time taken to dispense prescriptions was still improving, and staff were observed to give realistic waiting times to patients. It was highlighted that in the evening the waiting times are often increased.

The pharmacy had professional indemnity and public liability insurances in place. The pharmacy team recorded private prescriptions and emergency supplies and these were accurately recorded. The controlled drugs registers were up to date and legally compliant. The team did weekly checks on the recorded balance and actual stock of controlled drugs to ensure that there were no missing entries. Fridge temperatures were recorded daily and were within the recommended range.

Confidential waste was separated and bagged, and then stored in the cash office until collection by a licensed waste contractor. NHS cards, used to access NHS prescriptions and other information, were observed not to be shared, with staff observed removing their cards when they moved away from the computer terminals. The staff had had training about the General Data Protection Regulation (GDPR) and general information governance. There was a privacy notice on the consultation room door.

The pharmacist had undertaken formal training on safeguarding and the staff had done internal training on the matter. They were aware of who they should contact if they thought there might be an issue,

and had the local contacts for the safeguarding boards in the area.

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

Summary findings

The pharmacy is currently up to date with routine tasks and dispensing but this is only because one permanent member of staff is working excessive hours. This is not sustainable. And their hours are due to be reduced. This could mean that some tasks are not completed in a timely way. The staff are suitably trained for their role. And they do receive some support from the company to keep their skills and knowledge up to date.

Inspector's evidence

There was a regular locum and a dispenser present during the inspection, as well as a counter assistant. It was reported that there had been no pharmacy manager, or assistant manager for almost one year, but a new manager had just been appointed. The locum pharmacist described the pharmacy as running better than it had been when he had first gone to the pharmacy. The dispenser reported that she was employed to work 28 hours a week, but was regularly working from 8:30 to 18:30 six days a week to try to keep on top of the workload. Following the inspection it was reported that overtime was being cut, so that she would no longer be able to work these hours. However, it was likely that some jobs may not be done. From 06:30 to 08:30 and 19:00 to 22:30, the pharmacist was working alone. During the evening there were more walk-in prescriptions than might be expected as the Hertford County Hospital out-of-hours service was close by and so was not a quiet time. The pharmacist said that he would start to log the number of prescriptions using the walk-in service at that time to show the need for extra staff. He always had a break between dispensing and checking items when he was working on his own, to reduce the risk of dispensing errors.

The dispenser and counter assistant both reported that they had had an annual appraisal with the regional pharmacist, as there was no regular pharmacist in post. The dispenser had regularly reported the issues with the staffing to them and felt that they were supporting her and the counter assistant But the lack of regular staff meant that her responsibility had increased, as well as her working hours. She said that she sometimes felt that she was expected to take on more responsibility than she had been trained for.

Training time was allocated to the staff for training, and they were provided with formal training from the ‘Tesco Academy’ which the staff said was useful to remind them about current medications and changes to the law.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The pharmacy was clean tidy and bright. There were a few prescriptions dispensed and stored on the floor. These did not prevent access to the shelving in front of them, although they were a trip hazard. But the flooring in the dispensary was very worn in the areas in front of the computer terminals. The dispensary area was large and adequate for the volume of prescriptions. And there was enough bench space for dispensing prescriptions.

There was a consultation room which was also clean, tidy and bright and had adequate space for the services provided. It was kept locked and there was no confidential material accessible by people using the room, even if the pharmacist left the member of the public alone for a few minutes.

When the pharmacy closed, blinds were pulled up over the dispensed medicines and pharmacy only medicines so that they could not be viewed by the public.

Staff had access to the toilet facilities in the store, which had suitable handwashing facilities, and the dispensary had its own sink, with hot and cold running water.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. And it gets its medicines from reputable sources. However, the pharmacist often has to dispense and check prescriptions themselves. This could increase the chances that mistakes aren't spotted. And some systems for monitoring higher-risk medicines are not robust. So, some people may not get the advice they need to take their medicines safely.

Inspector's evidence

Access to the pharmacy was level from the store and was well signposted from the car park. Services were advertised on the wall of the pharmacy. Large print labels were available for those people with poor eyesight. There was a hearing loop. It was reported that the extended hours which the pharmacy opened provided a service for people using the out-of-hours prescribing service.

The use of baskets helped to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. Prescriptions where the person was waiting were put into red baskets to highlight this fact. Computer-generated labels included relevant warnings and were initialled by the dispenser and checker which allowed an audit trail to be produced. Following an incident all carrier bags used to put dispensed medicines in were sealed across the top using staples to prevent other items falling into them.

Schedule 4 controlled drug prescriptions were not always highlighted to staff who were to hand them out. This could increase the chance of these items being given out more than 28 days after the date on the prescription. Prescriptions for warfarin, lithium or methotrexate were sometimes flagged by the locum pharmacist, and then staff would ask about any recent blood tests or the person's current dose. But if the pharmacist did not flag the prescription the staff would not always notice the medicine and ask the questions. So, the pharmacy could not show that it was always monitoring the patients in accordance with good practice. People in the at-risk group who were receiving prescriptions for valproate were routinely counselled about pregnancy prevention. And appropriate warnings stickers were available for use if the manufacturer's packaging could not be used.

The pharmacy had taken part in the 2019 to 2020 flu vaccination campaign, although the lack of pharmacist manager had prevented making bookings as the staff did not know if individual locum pharmacists would be able to provide the service. This had reduced the number of people treated. The responsible pharmacist present was able to undertake vaccinations and the patient group direction was present and in date and he had done the appropriate training for a safe service.

A few people were being supplied their medicines in multi-compartment compliance packs. These packs were labelled with the information the person needed to take their medicines in the correct way. The packs also had tablet descriptions to identify the individual medicines. There was a list of packs to be dispensed each week, with each person having a summary sheet showing any changes to their medicines and where the medicines were to be placed in the packs.

The pharmacy got its medicines from licensed wholesalers and stored them on shelves in a tidy way. There were 'use first' stickers on the shelves and boxes to indicate items which were short dated. Regular date checking was done now, although it had been a bit irregular in the past few months. Drug

alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets. Electrical equipment was regularly tested. Stickers were affixed to various electronic equipment and displayed the next date of testing.

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.