General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Tring Road, AYLESBURY, Buckinghamshire, HP20 1PQ

Pharmacy reference: 1029084

Type of pharmacy: Community

Date of inspection: 17/04/2024

Pharmacy context

This is a community pharmacy inside a supermarket close to the centre of Aylesbury, Buckinghamshire. The pharmacy dispenses NHS and private prescriptions. It's team members sell over-the-counter medicines and provide advice. And the pharmacy offers the Pharmacy First Service, the New Medicine Service (NMS), as well as 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	1.2	Good practice	The pharmacy regularly reviews and monitors the safety and quality of its services. The team routinely records, reviews and feeds back near misses and incidents.
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 effectively identifies and manages the risks associated with its services. Members of the pharmacy team monitor the safety of their services by recording their mistakes and learning from them. This has made internal processes safer. Team members understand their role in protecting the welfare of vulnerable people. The pharmacy protects people's private information appropriately. And the pharmacy generally keeps the records it needs to by law.

Inspector's evidence

This was a well-managed pharmacy with competent staff, efficient processes, and systems in place. This helped promote safe practice and identify as well as suitably manage risks associated with the pharmacy's services. This included current documented and electronic standard operating procedures (SOPs) which provided the team with guidance on how to carry out tasks correctly. The staff had read and signed them. Members of the pharmacy team understood their roles well and worked in accordance with the company's set procedures. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display. This provided details of the pharmacist in charge of the pharmacy's operational activities.

Staff explained that no dispensing took place in view of people using the pharmacy's services. One dispenser was required to watch the counter and this team member generated dispensing labels for prescriptions from a position where both tasks could easily take place. However, they did not dispense prescriptions as they explained that the risk of distractions led to mistakes. Staff ensured that the pharmacy technicians did not cover the medicines counter, they worked in their own section at the very rear which again, limited the likelihood of distractions occurring. Appropriate waiting times were given to people waiting and marked on prescriptions.

Team members were observed to concentrate on one task at a time. They took care when dispensing, used prescriptions to select medicines against and ensured a three-way check against the prescription, dispensing label and medicine took place during the assembly process. Different members of staff participated in printing and generating dispensing labels as well as preparing prescriptions. The person who generated dispensing labels, did not select the medicines involved or prepare the prescription(s). This helped identify any errors and enabled more than one accuracy check to take place. In addition, a further accuracy-check of dispensed prescriptions also took place upon hand-out. Trained staff opened bags and the contents were re-checked against prescriptions. Team members involved in this process and details of the pharmacist were marked onto prescriptions to help identify that this process had taken place and was an effective audit trail.

The pharmacist also explained that when she first started, the pharmacy's top 50 lines were stored above the area where pharmacists' accuracy-checked prescriptions from. This meant that they were being constantly interrupted and distracted when staff required stock. Subsequently, additional space was made to accommodate these medicines in a different area of the dispensary.

Members of the pharmacy team routinely recorded their near miss mistakes. The details were reviewed and fed back to help reduce the likelihood of mistakes recurring. In response, staff highlighted medicines that had been commonly involved in mistakes on prescriptions when they generated

dispensing labels such as those that looked-alike and sounded-alike (LASAs). They also highlighted the form of the medicine and quantities to help prevent selection errors (for example where tablets had been selected instead of capsules or vice versa). Examples of this were seen. Lasa's were separated and highlighted amongst the pharmacy's stock. This included storing prednisolone and methotrexate in clearly defined locations.

Pharmacists oversaw incidents, their process was suitable and in line with requirements. This involved appropriate management of the situation, formal reporting, and investigation to identify the root cause. The necessary changes were then implemented into the pharmacy's internal systems.

Staff had been trained to safeguard the welfare of vulnerable people and the responsible pharmacist (RP) was trained to level two. Team members could recognise signs of concerns, they knew who to refer to in the event of a concern and contact details for the local safeguarding agencies were on display. The pharmacy's team members had also been trained to protect people's confidential information. Details were on display in the retail area explaining the pharmacy's privacy policy. No sensitive details were left or could be seen from the retail space. This included bagged prescriptions awaiting collection. Staff described using the consultation room to discuss sensitive details. They also ensured that the contents of assembled bags were opened in the rear sections of the dispensary when accuracy-checking the contents before supplying. This ensured the contents were not visible to others. Team members used their own NHS smart cards to access electronic prescriptions. They stored and disposed of confidential material appropriately.

The pharmacy had current professional indemnity and public liability insurance. The RP record, records of supplies made against private prescriptions, unlicensed medicines and to verify that fridge temperatures had remained within the required range had been routinely completed. A sample of registers seen for controlled drugs (CDs) had been maintained in accordance with legal requirements. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy had also been maintained appropriately. However, some records did not always include the nature of the emergency when a supply of a prescription-only medicine was made, in an emergency without a prescription. This could make it harder for the pharmacy to justify the supplies made. This was discussed at the time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an adequate number of staff to manage its workload. Members of the pharmacy team are very capable with a range of skills and experience. The company provides its team members with resources so they can complete ongoing training. This helps keep their skills and knowledge up to date. However, their performance has not been reviewed for some time. This could limit their ability to discuss feedback and concerns.

Inspector's evidence

Staff on the day of the inspection included two trained dispensing assistants and a pharmacy technician alongside the regular RP. The pharmacy's team members wore uniforms and name badges which indicated the length of their employment. Team members seen were very experienced and long-standing staff. They were observed to be competent and efficient in their role(s), and they worked well together. There were also newer team members who were enrolled on the appropriate training and were being suitably supported. In total, the pharmacy had eight part-time dispensing staff who also covered the counter and two regular pharmacists, one of whom was the pharmacy manager.

As the team were part-time, the levels of staff compared to the pharmacy’s volume of dispensing was low and the pharmacy was said to be consistently a few days behind with the workload. However, the pharmacy was up to date with other routine tasks and the RP explained that her ability to accuracy-check prescriptions was being affected due to the Pharmacy First service taking priority (see Principle 4). Staff seen were managing the workload as best they could.

The team knew which activities could take place in the absence of the RP and referred appropriately. Relevant questions were asked before selling medicines and medicines which could be abused were monitored. Staff said that they could easily discuss relevant details amongst themselves and used an electronic messaging application if needed. A range of training material was available through the company’s online platform which team members routinely completed but they had not had any performance reviews for many years.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a suitable environment for the delivery of its services. The pharmacy is clean. And it has a separate space for private conversations and services to take place.

Inspector's evidence

The pharmacy was situated at the back of the supermarket. Its premises consisted of a small retail section and front counter, a dispensary which extended to one side and a relatively spacious rear section which was used to store stock as well as bulky assembled items. The pharmacy also had a separate consultation room to hold private conversations and provide services. The room was signposted and of an adequate size for its purpose. The lighting and ambient temperature within the pharmacy was appropriate for storing medicines and safe working. The dispensary was screened well which provided appropriate privacy when dispensing prescriptions. It had adequate space for staff to carry out dispensing tasks safely and dispensing benches were kept clear of clutter. The pharmacy was clean and overall, presented professionally although the fixtures and fittings were dated in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is open for extended hours and team members help ensure that people with a range of needs can easily access the pharmacy's services. The pharmacy obtains its medicines from reputable sources, and it stores as well as manages them well.

Inspector's evidence

The pharmacy was open from 8am to 8pm Monday to Saturday, and from 10am to 4pm on Sundays. Details about the pharmacy's services as well as its opening times were clearly advertised, and the pharmacy had some leaflets on display to provide information about various health matters. People could enter the pharmacy from the supermarket's main entrance, which had powered doors and was step free. The area outside the pharmacy and leading up to it consisted of clear, open space and wide aisles which further assisted people with restricted mobility or using wheelchairs to easily enter and access the pharmacy's services. Staff described making reasonable adjustments for some people with different needs if this was required. This included providing people with written details, communicating verbally to people who were visually impaired, speaking slowly, loudly if possible or using the consultation room if needed. Some team members were also multilingual. This assisted people whose first language was not English. Staff were aware of the local health facilities to signpost people accordingly if this was required. They also had access to documented information to assist with this.

The workflow in the dispensary involved staff deciding every morning how to manage the workload. They rotated tasks and prepared prescriptions in designated areas. People waiting for their prescriptions took priority and medicines were checked for accuracy by the RP from another section. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer. The baskets were also colour coded which helped identify priority and different workstreams. Once staff generated the dispensing labels, there was a facility on them to help identify who had been involved in the dispensing process. Team members routinely used these as an audit trail. Staff were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). They ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them, and only provided full packs. They had also identified people in the at-risk group who had been supplied this medicine, ensured people were counselled appropriately and supplied relevant educational material.

The pharmacy had begun providing the recently commissioned Advanced NHS service, Pharmacy First Service. The service specification and Patient Group Directions (PGDs) to authorise this were readily accessible and had been signed by the pharmacists. Suitable equipment was present which helped ensure that the service was provided safely and effectively (see Principle 5). The pharmacists had also been trained on how to use them. Flow charts and checklists were due to be provided by the company for the team to use as reference. People had received medication for certain conditions under this service and the odd appropriate referral from GP practices were now being seen. The RP explained that the pharmacy had experienced some initial challenges when the service first started. This included long queues for the pharmacist to access this service, and people being referred to the pharmacy by their GP without realising what the service involved. The pharmacists were looking to actively reach out to local GPs to help resolve this.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Medicines were stored in an organised way. CDs were stored securely and the keys to the cabinet were maintained in a way which prevented unauthorised access. The team checked medicines for expiry regularly and kept records of when this had taken place. Short-dated medicines were routinely identified and on randomly selecting some of the pharmacy's stock, there were no medicines seen which were past their expiry date. Fridge temperatures were checked daily. Medicines which were returned to the pharmacy by people for disposal, were accepted by staff, and stored within designated containers. This did not include sharps or needles which were referred elsewhere appropriately. Drug alerts were received electronically. Staff explained the action the pharmacy took in response and relevant records were kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. And team members use them appropriately to keep people's confidential information safe.

Inspector's evidence

The pharmacy's equipment was suitable for its intended purpose. This included standardised conical measures for liquid medicines and triangle tablet counters, appropriately operating pharmacy fridges, legally compliant CD cabinets and access to current reference sources. Additional equipment for the pharmacy's services included an otoscope, tongue depressors, and a thermometer which were new. Portable telephones helped conversations to take place in private if required. The pharmacy's computer terminals were password protected and their screens faced away from people using the pharmacy. Team members took their NHS smart cards home overnight. This helped prevent unauthorised access.

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.