General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Tesco Superstore, Manchester Road, NORTHWICH, Cheshire, CW9 5LY

Pharmacy reference: 1029682

Type of pharmacy: Community

Date of inspection: 21/07/2022

Pharmacy context

This is a supermarket pharmacy located in the foyer of the store. It opens for extended hours, seven days a week. NHS dispensing is the main activity and the pharmacy also provides other NHS services and sells a range of over-the-counter medicines

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 team learn from things that go wrong and take action to prevent similar mistakes happening again.
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

Members of the pharmacy team follow written instructions to help them work safely and effectively. They record things that go wrong so that they can learn from them. And they take action to stop the same mistakes from happening again. The pharmacy keeps the records that are needed by law. And staff participate in regular training so that they know how to keep private information safe.

Inspector's evidence

The pharmacy had a full set of standard operating procedures (SOPs) that were available on the pharmacy computer. The SOPs were updated regularly and records were kept electronically showing each member of the team had completed training for all of them. The pharmacist explained that any dispensing errors would be recorded online and reported to head office. The records were also printed off and reviewed at the branch to identify learning points. A recent example involved Cyclizine tablets being supplied instead of Hydroxychloroquine tablets. This appeared to have happened because the manufacturer’s packaging for the two medicines was very similar. The error record had been signed by all members of the team to confirm they had been informed about the incident. Near miss incidents were also recorded and monthly reviews were carried out to identify trends and risks. The team gave several examples of action they had taken to avoid mistakes being repeated: warning signs had been placed near some medicines, some similarly named medicines had been separated on dispensary shelves, and some stock packs had been highlighted to make the name of the medicine more prominent. Sumatriptan had been deliberately separated from Sertraline following a picking error. And a pharmacy technician explained that when these medicines were received in stock orders, the person putting the stock on the shelves would always double check with another person to make sure it was correct.

A responsible pharmacist (RP) notice was displayed behind the medicines counter. Staff roles and responsibilities were described in the SOPs. And dispensing labels were initialled by the dispenser and checker to provide an audit trail. The pharmacy had a complaints procedure, but there was no information displayed to explain how people could make complaints or provide feedback. Evidence of current professional indemnity insurance was provided.Controlled drugs (CD) registers appeared to be in order. Running balances were recorded and a full audit of running balances was completed every week. A random balance was checked and found to be correct.

Patient returned CDs were recorded separately and regularly destroyed. Records of RP, private prescriptions, emergency supplies and unlicensed specials were all in order.An information governance (IG) policy was in place and all staff received annual training.

Confidential waste was collected in a separate bin. A privacy notice was displayed on the consultation room door but was not easily visible from the retail area, particularly if the door was left open. The notice contained little information itself but advertised that full details were available on the pharmacy website. This meant some people may not be made aware of how the pharmacy handled their data. A safeguarding policy was in place and the pharmacist confirmed he had completed level 2 training. All members of the team also completed training.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to effectively manage the workload and they receive the training they need for the jobs they do. Members of the team work well together; they are able to use their professional judgement and they know how to raise concerns.

Inspector's evidence

The pharmacy employed two regular pharmacists, who covered most of its extended opening hours between them. Locum pharmacists were employed to cover their days off. There were also two pharmacy technicians, one of whom worked as an accuracy checker (ACT), three dispensers and a trainee pharmacy assistant. During the inspection there was one pharmacist working with a pharmacy technician and a dispenser. The team were kept busy but managed the workload comfortably. The pharmacist said the staffing level was normally adequate but staff who had left recently had not been replaced, so he felt they were now operating on the minimum staffing level that was needed. The pharmacy had previously also been able to draw temporary staff from supermarket employees who had been pharmacy trained. But no such staff were currently employed so this was no longer an option.The dispenser explained that she completed regular training modules, which were recorded on her electronic training file. Recent training included information governance and safeguarding. The team used the WWHAM protocol to ask questions, when they sold over-the-counter medicines, to satisfy themselves that they were suitable. The dispenser explained that she often refused sales because people were trying to repeatedly purchase medicines that could be misused, such as co-codamol. Members of the pharmacy team appeared to work well together and had a good rapport with customers. A whistleblowing policy was in place and the pharmacy technician said she knew how she could raise a concern if it was necessary. The pharmacist explained that some performance targets were set, including for NMS, and the pharmacy was generally able to meet them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy and it provides a suitable environment for healthcare. There is a consultation room available so people can have confidential conversations.

Inspector's evidence

The pharmacy was located inside the foyer of a large supermarket. The counter had Perspex screens fitted to help prevent the spread of infection and it was gated to prevent unauthorised access. The dispensary was behind the medicines counter separated by a shelving unit that provided privacy for the dispensing operation. The shelves were low enough for the pharmacist to see over the top, so he was able to supervise.The pharmacy was clean and tidy and, although the dispensary was fairly small, it was well organised and there was enough clear bench space to allow safe working. There was a dispensary sink fitted with hot and cold water. Air conditioning was available, and all parts of the pharmacy were well lit. A consultation room was available for privacy. It was located behind the medicine counter but was clearly visible and people using the room did not need to enter the dispensary so would not be likely to see anything confidential. It was equipped with a desk and chairs and was clean and tidy.
The pharmacy was independently alarmed and was locked when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services and they are easy to access. But they are not well advertised so people may not know about some of the services that are available. The pharmacy team works effectively so that people receive appropriate care. But members of the team may not always know when they are handing out higher-risk medicines. So they could miss opportunities to counsel patients to help them use their medicines safely. The pharmacy obtains its medicines from licensed suppliers and carries out checks to make sure that they are kept in good condition.

Inspector's evidence

The pharmacy was close to the supermarket entrance where it was easy to access, including for people with reduced mobility. The Consultation room was suitable for wheelchair users, but it was located inside the entrance gate which could make access more difficult. There were a few posters outside the pharmacy giving information about NHS services, but there was a general lack of information about the range of services the pharmacy offered.Dispensing baskets were used to keep individual prescriptions separate and avoid medicines being mixed up during dispensing.

The pharmacist explained that some prescriptions were accuracy checked by an ACT. This was only allowed after the prescription had been clinically checked by a pharmacist, which was recorded by initialling the prescription form. Prescriptions waiting to be checked by the ACT were placed in different coloured baskets so they could be easily recognised.Dispensed medicines awaiting collection were bagged and kept on designated shelves. Prescription forms were filed separately in alphabetical order so that they could be retrieved when the medicines were handed out. Text messages could be sent to alert people that their prescription was ready to be collected. The pharmacist explained that the collection shelves were checked regularly and uncollected prescriptions were removed when they had expired. But the pharmacy did not have a system to highlight when CDs or high risk-medicines were present, so members of the team would not always know when these were being handed out.

The pharmacy team was aware of the risks associated with the use of valproate during pregnancy. A warning notice had been put near the valproate stock and educational material was available to supply if needed. The pharmacist explained that an audit had previously been carried out and the pharmacy did not currently supply valproate to anyone meeting the risk criteria. But he knew any such patients should be counselled if they presented.

The pharmacy technician confirmed people were always asked for their name and address before medicines were handed out, to make sure they were correctly identified. And people were also asked to read the bag label to make sure they were receiving the right thing. Owing slips were not normally used when the full amount could not be supplied. Instead, a note was made on the prescription form and it was kept on clip until the balance was collected. The pharmacist said this system had not caused any difficulties. But there was a risk that people could be unaware that they were still owed some medicines.The pharmacy supplied medicines in multi-compartment compliance aids (MDS) for about 20 patients. A file was kept containing record sheets for all the patients, showing their current medicines and dosage times. The pharmacist confirmed that patient information leaflets were routinely supplied.The pharmacy obtained its medicines from licensed wholesalers and unlicensed specials were

ordered from a specials manufacturer. No extemporaneous dispensing was carried out. Stock medicines were stored in orderly fashion. Expiry date checks were recorded on a chart. The records showed that a section of dispensary stock was checked every week, so that all the stock was checked about every three months. Short-dated stock was highlighted and listed in a book so that it would be removed before it expired. There was a medicines fridge in the dispensary. It was clean and tidy and equipped with a thermometer. The maximum and minimum temperatures were recorded daily were within the required range.Controlled drugs were appropriately stored in two standard cupboards. Waste medicines were disposed of in a dedicated bin that was kept in the dispensary. The bins were collected periodically by a specialist waste contractor. Drug alerts were received by e-mail from the head office. The e-mails were printed off and initialled to show that they had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. Equipment is appropriately maintained so that it is safe to use, and it is used in a way that protects privacy.

Inspector's evidence

The pharmacy had various reference books, including a recent edition of BNF, and the team could access the internet for general information. Crown stamped measures were used to measure liquids. Electrical equipment appeared to be in good working order.The dispensary was screened to provide privacy for the dispensing operation. The consultation room was used for services that required privacy and for confidential conversations and counselling. A sharps bin was available for disposing of used syringes. Pharmacy computers were password protected and screens were positioned so that they were not visible to the public.

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.