General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, George Street, DRIFFIELD, North Humberside, YO25 6RA

Pharmacy reference: 1032025

Type of pharmacy: Community

Date of inspection: 08/10/2019

Pharmacy context

This community pharmacy is in a Tesco supermarket in the market town Driffield. The pharmacy dispenses NHS and private prescriptions. And it supplies multi-compartment compliance packs to help people take their medicines. The pharmacy provides a seasonal flu vaccination service. And it sells over-the-counter medicines.

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 identifies and manages the risks associated with its services. And it keeps most records it needs to by law. The pharmacy has written procedures that the team follows. And it has appropriate arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The team members have some level of training and guidance to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They take the action needed to help prevent similar mistakes happening again. But they don't fully record all their errors. So, the team does not have all the information it could to help identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The pharmacy had SOPs' signature sheets to show the team member understood and would follow them. Some of the team members signatures were from 2014 rather than against the updated SOPs. So, they may not be aware of any changes to the revised SOPs. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The dispensers highlighted to each other errors picked up when dispensing. For example, when one dispenser spotted an error on a dispensing label generated by another dispenser. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to help spot patterns. And the team members recorded what caused the error. But they did not record their learning from the error and actions they had taken to prevent the error happening again. The near miss error record included a flow chart for the pharmacists to track the type of error and who in the team was involved. The pharmacists undertook weekly reviews of the error records to spot patterns. And discussed the results with the team. So, the team could act to reduce errors. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. The team members printed off the report for reference. And they recorded the incident on the person's electronic record (PMR).

The pharmacy completed an annual patient safety report. The latest report included the actions taken by the team after identifying different pack sizes for the same product. The team members separated the different pack sizes to help them pick the correct quantity. And they highlighted to each other the different pack sizes received from the wholesaler. The team kept high-risk medicines such as warfarin on a designated shelf. This was in response to incidents in other pharmacies. The team were reminded to be extra vigilant and careful when dispensing a prescription for these medicines. The team identified the risks associated with people who had the same or similar names. Such as selecting the wrong person from the PMR when labelling medicines. So, the team generated a list of people with similar names and updated the PMR with alert notes. The PMR notes prompted the team members to check the person's date of birth and address to ensure they had the correct person. The PMR note included a request for the person to click OK to show they had read this information before they continued to

label the prescription. The team also placed warning stickers on the pharmacy bags. The labels acted as further prompt for the team to check the name of the person when handing the medicines over. The pharmacy had a procedure for handling complaints raised by people using the pharmacy. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And in the consultation room for people to read.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy also kept CD registers for temazepam even though this was not a legal requirement. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies met legal requirements. But some records of emergency supply requests did not include the reason why the supply was made without a prescription. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). And it displayed a notice informing people to visit the Tesco website to see the GDPR privacy notice. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The two regular pharmacists had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The team had not had the occasion to report a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. It gives the team members opportunities to complete regular training relevant to their roles. And so, keep their skills and knowledge up to date. The team members support each other in their day-to-day work. They identify improvements to the delivery of pharmacy services. And they introduce processes to improve their efficiency and safety in the way they work.

Inspector's evidence

A full-time pharmacist manager and a full-time duty pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of two part-time registered pharmacy technicians one who was an accuracy checking technician, a part-time trainee pharmacy technician, three part-time dispensers and a part-time trainee medicines counter assistant (MCA). At the time of the inspection the duty pharmacist, one of the pharmacy technicians, the trainee technician and one of the dispensers were on duty. The trainee MCA was from one of the other teams in the store. And had been asked to join the team to cover hours especially during team absences.

The pharmacy provided extra training through e-learning modules. The team read and received a weekly patient safety bulletin from head office. The pharmacy had enrolled the pharmacists and the pharmacy technicians on to training provided by the Centre for Pharmacy Postgraduate Education (CPPE) on reducing errors with medicines that looked and sounded alike (LASA). So, the team could improve their knowledge in defining LASA medicines. And reduce the risk of errors with these medicines. The pharmacy provided performance reviews to the team. So, they had a chance to receive feedback and discuss development needs.

Team members could suggest changes to processes or new ideas of working. The pharmacist manager had used their experience from other pharmacies to introduce the use of clear plastic bags to hold dispensed controlled drugs and fridge lines such as insulin. So, the team could do another check before handing the medicine over to the person. The team had moved clopidogrel to the shelves holding the most common medicines so there was room to hold more stock. And this made it easier for the team to find the medicine when dispensing. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was some pressure to achieve them. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had recently undergone a refit which created a slightly larger dispensary. During the refit the mirror used by the team in the dispensary to see people at the pharmacy counter had been removed. The team asked for a replacement, but one had not been installed. The layout of the dispensary meant the team in the dispensary could not see people at the pharmacy counter. So, the team put a notice on the pharmacy counter asking people to let the team know when they arrived at the counter. The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people.

The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. And it manages its services well. The pharmacy keeps records of prescription requests. So, it can deal with any queries effectively. The pharmacy gets is medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via the store entrance through an automatic door. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role. The pharmacy provided the flu vaccination service against up-to-date patient group directions (PGDs). The PGDs gave the pharmacist trained to provide the service the legal authority to administer the flu vaccines. The flu vaccination service was popular. People commented on the convenience of the service. And the gentle technique employed by the pharmacist when administering the vaccine. The pharmacy supplied buprenorphine as unsupervised doses.

The pharmacy provided multi-compartmental compliance packs to help around 30 people take their medicines. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team labelled the prescriptions before dispensing and stored the label with the prescriptions in a dedicated section of the dispensary. So, everyone in the team could see what packs were waiting to be dispensed. The dispensary was small with limited work space. The team dispensed the packs when there was space to do this. After completing other activities such as putting the stock order away. The team recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets. The pharmacy received copies of hospital discharge summaries. The team members checked the discharge summary for changes or new items. And they kept the discharge summary to refer to when queries arose.

The team members provided a repeat prescription ordering service. And they collected prescriptions from the GP surgeries on behalf of people who had ordered their medicines. The team members kept records of the prescription requests and prescriptions to collect. The records included the number of medicines. So, the team could match the number of medicines expected with the prescription. And query any missing items. The team usually ordered the repeat prescriptions a few days in advance of supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had the PPP pack containing information to give to people when required. The team used the electronic medication record (PMR) to record information received from people. For example, the team recorded whether a person taking medication to treat diabetes had received a foot check or an eye check in the last 12 months.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members

referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team members to do another check of the dispensed medicines before they transferred the medicine to a pharmacy bag to give to the person. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacists initialled the bottom corner of the prescription to show they had completed a clinical check of the prescribed medicines. So, the accuracy checking technician could check the dispensed medicines. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy had a text messaging service to inform people when their repeat prescriptions or owings were ready.

The pharmacy had large plastic boxes to hold stock rather than keeping the medicine containers loose on the shelves. This helped to prevent the shelves from becoming untidy. And helped to reduce picking errors. The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 27 September 2019. The team used a coloured sticker with the expiry date written on to highlight medicines with a short expiry date. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of cetirizine oral solution with six months use once opened had a date of opening of 03 August 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The team recorded the extra readings taken when the first reading was outside the range. So, they could show the fridge temperatures were correct. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no equipment or procedures to meet the requirements of the Falsified Medicines Directive (FMD). And the team did not know when the pharmacy would have the FMD equipment installed. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team actioned the alert and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people’s private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.