General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Hewitts Circus Retail Park, Hewitts Avenue, CLEETHORPES, South Humberside, DN35 9QR

Pharmacy reference: 1032453

Type of pharmacy: Community

Date of inspection: 19/08/2019

Pharmacy context

This is a community pharmacy set within a supermarket, on the outskirts of a popular seaside resort town in Lincolnshire. The pharmacy opens over seven days each week. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. And it supplies some private health services including a travel health service.

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	Pharmacy team members act openly and honestly by sharing information when mistakes happen. They continually discuss any learning and make changes to their practice to improve patient safety. And they complete regular audits to measure the effectiveness of these actions.
		1.8	Good practice	The pharmacy promotes a clear culture of safeguarding the safety and wellbeing of vulnerable people. And it reports concerns to protect the welfare of these people.
2. Staff	Standards met	2.5	Good practice	The pharmacy promotes how its team members can provide feedback. And feedback is used to inform service delivery and wider learning amongst the pharmacy profession.
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. It keeps people's private information secure. And it responds appropriately to feedback it receives about its services. The pharmacy promotes a clear culture of safeguarding the safety and wellbeing of vulnerable people. And it reports concerns to protect the welfare of these people. Pharmacy team members act openly and honestly by sharing information when mistakes happen. They continually discuss any learning and make changes to their practice to improve patient safety. And they complete regular audits to measure the effectiveness of these actions. The pharmacy generally keeps all records it must by law. But some minor gaps in these records occasionally result in incomplete and inaccurate audit trails.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). These included responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The superintendent pharmacist's team reviewed these at least two yearly. And the next planned date for review was July 2020. The SOPs set out the roles and responsibilities of staff. Pharmacy team members had read and signed SOPs relevant to their role. A trainee member of the team clearly identified the tasks she could and couldn't complete if the RP took absence from the premises. Pharmacy team members were observed working in accordance with dispensary SOPs. For example, they completed a 'bag check' of all assembled medicines against the original prescription prior to handing them out. They explained how this process further helped to reduce the risk of a mistake occurring during the dispensing process.

The pharmacy team managed space in the dispensary well. There were designated areas for labelling, assembling and accuracy checking medicines. As well as a protected area for the bag check and space for administration tasks. All pharmacy team members contributed to completing 'safe and legal' checks. This process formed a continuous audit of daily and weekly checks designed to support the team in maintaining a safe and secure working environment. Details checked included record keeping, patient safety and equipment used to support the delivery of the pharmacy's services.

Pharmacy team members took ownership of their mistakes by discussing them with the pharmacist at the time they occurred. They then completed an entry into the near-miss error log. Reporting was seen to be consistent and contributory factors were generally identified within entries. The error log was reviewed weekly by a pharmacist manager. And feedback following the review was documented and shared with pharmacy team members either in small group meetings or one-to-one conversations. Pharmacy team members explained how they took this feedback on board by adopting improvements to their dispensing process. For example, they ticked through information on assembled medicines as they applied a check of their own work prior to handing over to the pharmacist for an accuracy check.

The pharmacy had a dispensing incident reporting procedure in place. And the pharmacy team demonstrated an open and honest approach to incident reporting. Incident reports were submitted to the superintendent pharmacist's office. And monitoring processes were in place to support the pharmacy in applying risk reduction actions to help reduce the risk of similar mistakes occurring. Completed incident reports clearly documented learning and risk reduction actions applied following an

incident. For example, pharmacy team members separated 'look alike and sound alike' (LASA) medicines within the dispensary drawers. And they had recently completed some calculation training. A summary of incidents along with the teams 'next steps' was available to staff. This helped to remind them of the actions required to improve patient safety in the pharmacy. Pharmacy team members were knowledgeable about these actions and could demonstrate how they applied them.

The pharmacy had a complaints procedure in place. And it provided details of how people could leave feedback or raise a concern about the pharmacy through its practice leaflet. A member of the team explained how she would manage a complaint and understood how to escalate concerns if required. The pharmacy documented the concerns it received. The documentation included formal responses and the actions taken to share learning following a concern. For example, information relating to sign-posting to a late-night pharmacy when the pharmacy could not provide a service had been shared with locum pharmacists. The pharmacy also promoted feedback through their annual 'Community Pharmacy Patient Questionnaire'. It published the results of this questionnaire for people using the pharmacy to see.

The pharmacy had up to date indemnity insurance arrangements in place. The RP notice contained the correct details of the RP on duty. And the notice was changed immediately when the role of RP was passed to a different pharmacist during the inspection. Entries in the responsible pharmacist record generally complied with legal requirements. There were a couple of recently missed sign-out times in the register. These were brought to the attention of a pharmacist who was able to check a personal log and retrospectively complete these entries. The pharmacy kept records for private prescriptions and emergency supplies within an electronic Prescription Only Medicine register. Entries within the register generally met legal requirements. But the pharmacy did not always record an accurate date of prescribing when completing the record. And some emergency supplies of medicines made at the request of a patient did not contain the nature of the emergency. The pharmacy retained completed certificates of conformity for unlicensed medicines with full audit trails completed to show who unlicensed medicines had been supplied to.

The sample of the controlled drug (CD) register examined was compliant with legal requirements. The pharmacy maintained running balances in the register. And it checked these balances against physical stock weekly. Physical balance checks of several morphine preparations complied with balances recorded in the register. The pharmacy maintained a CD destruction register for patient returned medicines. And the team entered returns in the register on the date of receipt. A note in the record, made at the time the last destruction of these medicines took place, stated a returned schedule three CD could not be found. The manager explained this had not been brought to her direct attention. But planned to follow the matter up with the pharmacist who had left the note.

The pharmacy displayed a notice explaining to people how it managed their personal data. All pharmacy team members completed mandatory information governance training. And they demonstrated how their working processes kept people's information safe and secure. All person identifiable information was stored in staff only areas of the pharmacy. The pharmacy had submitted its annual NHS information governance toolkit. It disposed of confidential waste in coloured bags. Bags were tied and transferred to a locked receptacle prior to being securely disposed of.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. Contact details for safeguarding teams were displayed in the dispensary. Pharmacy team members demonstrated good insight and knowledge of safeguarding reporting requirements. And they had information available to them to support them in recognising and managing a concern. Pharmacy team members had completed e-learning on the subject and pharmacy professionals had completed level

two learning in addition to the e-learning. Pharmacy team members regularly discussed safeguarding and they were encouraged to bring minor concerns to the attention of a pharmacist. The team shared examples of how the pharmacy had supported the safety and welfare of vulnerable people when required. And they had felt supported when sharing these concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services effectively. It has systems in place for supporting the learning needs of its team members through ongoing training and structured appraisals. Pharmacy team members engage in regular conversations relating to risk management and safety. And they show how they implement risk reduction actions following this learning. The pharmacy promotes how its team members can provide feedback. And feedback is used to inform service delivery and wider learning amongst the pharmacy profession.

Inspector's evidence

On duty at the beginning of the inspection was a regular locum pharmacist and a pharmacy technician. The team explained they were running with one member of staff short due to illness. Both members of staff took turns to serve on the medicine counter between completing dispensary tasks. Another pharmacist (the full-time manager), a pharmacy technician and another multi-skiller joined the team shortly after the inspection began. The pharmacy also employed another part-time pharmacy manager, another pharmacy technician, four dispensers and a trainee dispenser. Regular locum pharmacists covered the regular pharmacists' days off and leave. And pharmacist shifts overlapped six days a week. This provided cover for breaks and supported pharmacists in completing management tasks. The pharmacy was currently monitoring staffing levels due to increasing workload.

Multi-skillers worked solely on the medicine counter and completed medicine counter assistant training to support them in their role. One member of the team was enrolled on this training and confirmed feeling well supported in her role by all members of the team. Both pharmacists and pharmacy technicians on duty were observed supporting the trainee. A dispenser was enrolled on level three training in pharmacy services. All pharmacy team members engaged in continual learning to support them in their role. This learning ranged from discussions to completing e-learning modules. They did not receive protected learning time at work. But confirmed time for learning could be taken during quieter periods.

Pharmacy team members received an annual appraisal. They explained this focussed largely on the pharmacy's objectives. The pharmacy manager demonstrated how the appraisal paperwork for the current year had been updated and contained a personal development plan for each team member. Each team member was provided with a copy of the appraisal paperwork prior to meeting with the manager. This allowed them to think about their objectives ahead of the meeting.

The pharmacy was busy throughout the inspection. Pharmacy team members were observed completing tasks with efficiency and prioritised tasks well. The pharmacy did have some targets in place. These related to services, sales and prescriptions. The team expressed how prescription volume was continuously increasing, particularly in summer months due to tourists visiting the pharmacy. Pharmacists expressed they were happy to apply their professional judgement when working towards meeting targets. And they engaged the support of the team in identifying people who could benefit from the services provided.

The pharmacy team shared information relating to workload management at the beginning of shifts

through handovers. The pharmacy did not have full staff meetings due to shift patterns. But information was shared continuously through smaller team briefings and open discussions. And pharmacy team members were asked to sign news bulletins and patient safety reviews after they had read them. The pharmacy documented its improvement actions following these reviews and pharmacy team members were knowledgeable about the risk reduction actions implemented.

The pharmacy had a whistleblowing policy in place. And pharmacy team members were aware of how to provide feedback and escalate a concern if required. The pharmacy team had shared learning from incidents and through implementing processes with its superintendent pharmacist's team. This prompted wider learning through it being published in news bulletins read by pharmacy teams across the company. Recent feedback had been used to inform awareness of different strengths of hormonal replacement therapy. The pharmacy team had also shared learning around some issues with the clinical computer software programme recording erroneous exemption statuses. The pharmacy team had acted on this issue by informing people potentially affected to contact the pharmacy should they receive an incorrect fine notice.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to the standards required. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. It consisted of the medicine counter, dispensary and consultation room. The consultation room was sign-posted and was used by pharmacy team members with people who required privacy. The room was a good size and was professional in appearance. But the door to the room had dropped over time. This meant it was difficult for team members to open it wide. The matter had been reported.

The dispensary was a sufficient size for the level of activity carried out. And pharmacy team members managed work space vigilantly. Work benches were free from clutter. But some larger bags in the prescription assembly area did spill out onto the dispensary floor. A pharmacist re-arranged the overflow bags when the risk of trip or fall was discussed.

Pharmacy team members reported maintenance issues to a designated help-desk. The consultation room door was the only outstanding maintenance issue found during the inspection. The pharmacy was generally clean. But dust had built up in one section of the dispensary. This was brought to the attention of the manager. The pharmacy had air conditioning. Lighting throughout the premises was bright. Antibacterial soap was readily available at the pharmacy’s sinks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and makes them accessible to people. It has up-to-date procedures to support the pharmacy team in delivering its services. And its team follow these procedures well. People visiting the pharmacy receive advice and information to help them take their medicine safely. And the pharmacy identifies high-risk medicines to help make sure people taking these medicines have the support they need. The pharmacy obtains its medicines from reputable sources. And it keeps its medicines safe and secure.

Inspector's evidence

The pharmacy was clearly signposted from the main road and was easy to find within the store. There was step-free access into the store. The pharmacy advertised details of its opening times and services clearly. It had a small health promotion zone at the medicine counter. Pharmacy team members used their own local knowledge and information available on the internet to help signpost people to other healthcare organisations when required.

Prescription bags were annotated with stickers to help identify eligible people for some of the pharmacy's services. The pharmacy manager reflected on positive outcomes from Medicine Use reviews (MURs). Learning from outcomes was shared amongst pharmacists to inform service delivery. For example, placebo inhalers and asthma care plan tools were put into place to assist pharmacists in assessing and counselling people in the use of their medicines.

A pharmacy technician was observed explaining the importance of high-risk monitoring checks associated with warfarin to another member of the team. Pharmacy team members demonstrated how they highlighted prescriptions for high-risk medicines by using stickers. And they entered details of monitoring checks on people's medication records when these were available. The pharmacy team was knowledgeable about the requirements of the valproate pregnancy prevention programme (PPP) and warning cards were readily available to issue to people in the high-risk group.

The pharmacy had up-to-date patient group directions (PGDs) and procedures readily available to support the supply of medicines through its private services including its travel health and erectile dysfunction services. It maintained pharmacists training records which provided assurance that pharmacists offering these services had completed the required learning to provide these services effectively. The pharmacy also had an up-to-date protocol in place to support the supply of medicines through the local minor ailments service.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. The pharmacy had adopted a process known as 'Fast Queue'. This allowed the team to organise prescriptions for its managed workload by date and alphabetical order. The process informed workload management and meant prescriptions in the queue could be efficiently located. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. Those completing the 'third check' signed prescription forms to take ownership of this check. The pharmacy team kept original prescriptions for medicines owing to people. And it used the prescription throughout the dispensing

process when the medicine was later supplied. The pharmacy retained an audit trail for its prescription collection service. This allowed the team to chase missing prescriptions or chase queries ahead of collection due dates.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members discussed changes to medicine packaging introduced due to the Falsified Medicine Directive (FMD). But the pharmacy had no equipment in place to support the team in complying with FMD requirements. The pharmacy team received safety alerts and drug recalls via email. It acted upon these alerts in a timely manner and kept a copy for reference purposes. It also raised concerns about medicines with manufacturers on occasion. For example, the pharmacy manager had provided feedback about the clarity of information provided on product packaging to a manufacturer as this was thought to have contributed to a dispensing incident.

The pharmacy stored Pharmacy medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. The pharmacy stored medicines in the dispensary in an organised manner. The pharmacy team followed a date checking rota to help manage stock and it recorded details of the date checks it completed. Short-dated medicines were identifiable. The team annotated details of opening dates on bottles of liquid medicines. No out-of-date medicines were found during random checks of dispensary stock. Medical waste bins, clinical waste bins and CD denaturing kits were available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in a secure cabinet. Medicine storage inside the cabinet was orderly. There was designated space for storing patient returns, and out-of-date CDs. Assembled CDs were held in clear bags and clearly marked. Pharmacy team members could explain the validity requirements of a CD prescription and demonstrated how CD prescriptions were highlighted to prompt additional checks during the dispensing process. The pharmacy's fridge was clean and stock inside was stored in an organised manner. The pharmacy team monitored fridge temperatures. And recorded these within the safe and legal diary. A sample of the diary confirmed the fridge was operating between two and eight degrees Celsius as required

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the equipment and facilities it needs for providing its services. It regularly monitors its equipment to help provide assurance that it is in safe working order. And pharmacy team members manage and use equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. The pharmacy had some internet access. This was restricted to approved sites. Computers were password protected and information on computer monitors was protected from unauthorised view due to the layout of the pharmacy. Pharmacy team members used NHS smart cards to access people's medication records. The pharmacy stored assembled bags of medicines to the side of the dispensary. This protected people's private information against unauthorised view. The pharmacy's telephone handsets could be used when unplugged. This meant they could move out of ear-shot of the public area when having confidential conversations with people over the telephone.

Clean, crown stamped measuring cylinders were in place for measuring liquid medicines. And these included a separate measure for use with methadone. The pharmacy had clean counting equipment for tablets and capsules, including a separate counting triangle for use when counting cytotoxic medicines. It had the necessary equipment readily available to support its private health service. This included a working blood pressure machine, glucometer and cholesterol testing machine. These machines were regularly checked by the team and it recorded details of these checks. Stickers on electrical equipment showed portable appliance checks had last been carried out in February 2019.

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.