

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Wickhurst Lane,
Broadbridge Heath, HORSHAM, West Sussex, RH12 3YU

Pharmacy reference: 1037359

Type of pharmacy: Community

Date of inspection: 21/08/2019

Pharmacy context

This is a community pharmacy set within a supermarket on the outskirts of Horsham. It opens seven days a week. Most people who use the pharmacy also use the supermarket. The pharmacy sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers winter influenza (flu) vaccinations and private health checks.

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 has written procedures to help make sure its team works safely. It adequately monitors the safety of its services. It has appropriate insurance to protect people if things do go wrong. It generally keeps all the records it needs to by law. And it asks people using its services for their views. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They work to professional standards and identify and manage risks appropriately. They learn from the mistakes they make to try and stop them happening again. They understand their role in protecting vulnerable people. And they keep people's private information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place for the services it provided. And these have been reviewed since the last inspection. The pharmacy's team members were required to read, sign and follow the SOPs relevant to their roles.

The team members responsible for the dispensing process tried to keep the pharmacy's workstations tidy. They used plastic baskets to separate people's prescriptions and to help them prioritise the dispensing workload. The pharmacy had systems to record and review dispensing errors and near misses. Staff discussed individual learning points when they identified a mistake. They reviewed their mistakes periodically to help spot the cause of them. And they tried to stop them happening again; for example, they've separated some look-alike and sound-alike drugs to help reduce the risks of them picking the wrong product.

The pharmacy displayed a notice that identified the responsible pharmacist (RP) on duty. Members of the pharmacy team explained what they could and couldn't do, what they were responsible for and when they might seek help; for example, a member of the pharmacy team explained that repeated requests for the same or similar products were referred to a pharmacist.

A complaints procedure was in place and patient satisfaction surveys were undertaken annually. People could provide feedback about the pharmacy in-store, online or by contacting the company's customer service department. The results of last year's patient satisfaction survey were published online. Staff tried to keep people's preferred makes of medicines in stock when they were asked to do so.

The pharmacy had insurance arrangements in place, including professional indemnity, through the National Pharmacy Association (NPA).

The pharmacy's controlled drug (CD) register and its RP records were adequately maintained. The CD register's running balance was checked regularly. The nature of the emergency within the pharmacy's records for emergency supplies made at the request of patients didn't always provide enough detail for why a supply was made. The prescriber's details weren't always correctly recorded in the pharmacy's private prescription records. The date an unlicensed medicinal product was obtained at the pharmacy wasn't included in the pharmacy's 'specials' records.

An information governance policy was in place. But some team members still needed to read and sign it. A notice was displayed next to the pharmacy's counter to tell people how their personal data was

used and kept. Arrangements were in place for confidential waste to be collected and sent to a centralised point for secure destruction. The pharmacy stored its prescriptions in such a way to prevent people's names and addresses being visible to the public.

Safeguarding procedures were in place. And contact details for the relevant safeguarding authorities were available. Staff could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to deliver its services safely. But it doesn't currently have a person to lead its team. So, sometimes team members don't do all the tasks they're expected to do. The pharmacy's team members make appropriate decisions about what is right for the people they care for. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy opened for 84 hours a week. And it dispensed about 7,000 prescription items a month. The pharmacy team consisted of a full-time pharmacy manager, a full-time pharmacist, a part-time pharmacist, six part-time dispensing assistants, a full-time trainee medicines counter assistant (MCA) and three part-time trainee MCAs. The pharmacy relied upon locum staff and its team members to cover any staff vacancies or absences. The pharmacy's team members needed to complete or undertake accredited training relevant to their roles after completing a probationary period.

A locum pharmacist (the RP), a locum dispenser and a trainee MCA were working at the time of the inspection. Staff supported each other so prescriptions were processed in a timely manner. But queues quickly developed at the pharmacy counter during the inspection as no additional team members were available to cover staff breaks. The pharmacist supervised and oversaw the supply of medicines and advice given by staff. But they sometimes needed to self-check the prescriptions they assembled and deal with people at the pharmacy counter.

The pharmacy team was being led by locum pharmacists and supported by a locum dispenser as the pharmacy manager and the full-time pharmacist were absent from the business. So, some routine and managerial tasks weren't always done when they needed to be. And the pharmacy team concentrated on serving people and delivering the pharmacy's core services.

A sales of medicines protocol was in place which the pharmacy team needed to follow. The trainee MCA described the questions she would ask when making over-the-counter recommendations and when she would refer people to a pharmacist; for example, requests for treatments for animals, infants, people who were pregnant, elderly people or people with long-term health conditions.

The pharmacy's team members discussed their performance and development needs with their line manager. They were encouraged to learn from their mistakes and complete accredited training or additional training. But they didn't always get time to train nor read the company's newsletters as they were often too busy to do so. A 'WhatsApp' group and one-to-one discussions were used to update the pharmacy's team members and to share learning. Staff felt comfortable in making suggestions about how to improve the pharmacy. And they knew how to raise a concern if they had one. Their feedback led to the installation of an additional computer terminal in the dispensary.

The pharmacy's team members didn't feel their professional judgement or patient safety were affected by company targets. Medicines Use Reviews (MURs) and New Medicine Service (NMS) consultations were only provided by suitably qualified pharmacists when it was clinically appropriate to do so and when the workload allowed.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a suitable environment for people to receive healthcare.

Inspector's evidence

The pharmacy was bright, professionally presented and air-conditioned. It was situated near the health and beauty area of the supermarket. The pharmacy was cleaned by a cleaning contractor. But the cleaner wasn't left unsupervised in the pharmacy. The pharmacy's team members were also responsible for keeping the registered pharmacy area clean and tidy. But some areas of the dispensary were dusty. The pharmacy's sinks were clean. The pharmacy had a supply of hot and cold water. It also had some antibacterial hand wash and alcoholic hand sanitiser gel.

The pharmacy had the workbench and storage space it needed for its current workload. A consultation room was available if people needed to speak to a team member in private. And it was locked when not in use to ensure its contents were kept secure.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's working practices are safe and effective. And its services are accessible to most people. It gets its medicines from reputable sources and it stores them appropriately and securely. The pharmacy's team members check stocks of medicines to make sure they are fit for purpose. They make sure people have the information they need to take their medicines safely. And they generally dispose of people's waste medicines safely too.

Inspector's evidence

The supermarket had a large car park for people to use. It had automated doors and its entrance was level with the outside pavement. The pharmacy was open most days of the year and it opened early and stayed open later than usual six days a week. The pharmacy's services were advertised in-store and were included in the pharmacy's practice leaflet. The pharmacy team knew what services the pharmacy offered and where to signpost people to if a service couldn't be provided.

The pharmacy offered private patient group directions for malaria prevention and the treatment of erectile dysfunction. But the demand for these were minimal as over-the-counter products were now available. The pharmacy offered a winter flu vaccination service. Some people chose to be vaccinated at the pharmacy rather than their doctor's surgery for convenience or because they were not eligible for the NHS service. The pharmacy offered private health checks. And people needed to make an appointment for these. So, the pharmacy could make sure an appropriately trained member of staff was available to provide the service. People identified of being at significant risk of diabetes or heart disease during a health check were signposted to their clinician. The pharmacy's team members were clear about who was eligible for the service and the process they needed to follow. The pharmacy provided less than 20 MURs and very few NMS consultations a month. People were required to provide their consent when recruited for these services.

Staff followed the pharmacy's SOPs. They referred to prescriptions when labelling and picking products. And they initialled each dispensing label. Assembled prescriptions were checked by the RP who was also seen initialling the dispensing label. Patient information leaflets were routinely supplied. Prescriptions were highlighted to alert staff when a pharmacist needed to counsel people and when CDs or refrigerated items needed to be added. But prescriptions weren't handed out to people until an additional accuracy check was done at the point of supply. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Valproate educational materials were available at the pharmacy.

The pharmacy used recognised wholesalers, such as AAH, Alliance Healthcare, Oakwood Distribution Ltd. and Phoenix, to obtain its medicines and medical devices. It stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius. It kept its medicines and medical devices in an organised fashion within their original manufacturer's packaging. Its stock was subject to date checks and products nearing their expiry dates were appropriately marked.

The pharmacy stored its CDs, which were not exempt from safe custody requirements, securely. A record of the destruction of patient-returned CDs was maintained. Staff were required to keep patient-

returned and out-of-date CDs separate from in-date stock.

Staff were aware of the Falsified Medicines Directive (FMD). They could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't verifying or decommissioning stock at the time of the inspection as the pharmacy didn't have the appropriate equipment nor software to do so. The pharmacy's SOPs hadn't been revised to reflect the changes FMD would bring to the pharmacy's processes. And the pharmacy team didn't know when the pharmacy would become FMD compliant.

Procedures were in place for the handling of patient-returned medicines and medical devices. Patient-returned waste was emptied into a plastic tray and was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. Pharmaceutical waste receptacles were available and in use. But the pharmacy didn't have a receptacle to dispose of people's hazardous waste, such as cytostatic and cytotoxic products. And some intact patient-returned gabapentin capsules were found in a pharmaceutical waste bin.

A process was in place for dealing with recalls and concerns about medicines or medical devices. Drug and device alerts were received electronically and actioned by staff.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the appropriate equipment and the facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy had up-to-date reference sources available and it had access to the NPA's information department. The pharmacy had a range of clean glass measures. And it had equipment for counting loose tablets and capsules too. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its maximum and minimum temperatures were checked and recorded regularly.

The diagnostic equipment used by the pharmacy team for health checks needed to be replaced or checked regularly. The pharmacy's blood pressure monitor was replaced within the past two years. And staff explained that the accuracy of the pharmacy's blood glucose and cholesterol monitors were checked regularly. But they couldn't locate the pharmacy's calibration records to demonstrate this.

The pharmacy had a cordless telephone system to allow its staff to have confidential conversations with people when necessary. Access to the pharmacy computers and the patient medication record system was restricted to authorised personnel and password protected. The computer screens were out of view of 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.