General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Coldfield Drive, Oakenshaw Wood, REDDITCH, Worcestershire, B98 7RU

Pharmacy reference: 1038869

Type of pharmacy: Community

Date of inspection: 02/08/2024

Pharmacy context

This is a community pharmacy inside a supermarket in Redditch Worcestershire. 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 and COVID-19 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	1.1	Good practice	The pharmacy has a range of efficient processes with additional audit trails in place. This helps the pharmacy team to actively identify and manage risks associated with the pharmacy's services.
		1.2	Good practice	The pharmacy continually 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	2.2	Good practice	Members of the pharmacy team have the appropriate skills, qualifications and competence for their role and the tasks they undertake.
		2.4	Good practice	The pharmacy has adopted a culture of openness, honesty and learning. The RP in addition to the company provide team members with learning resources and additional training which ensures their knowledge and skills are kept up to date.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy provides its services well and routinely carries out interventions as well as ensuring suitable checks are made for people prescribed higher-risk medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy efficiently identifies and manages the risks associated with its services. Members of the pharmacy team monitor the safety of their services well. They do this by recording their mistakes and continually learning from them. They understand how to protect the welfare of vulnerable people. The pharmacy suitably safeguards people's confidential information. And it maintains its records as it should.

Inspector's evidence

The pharmacy was inspected in relation to a complaint made to the GPhC relating to a health and safety risk, but the inspector found this situation to have been managed appropriately. The pharmacy was clean and tidy. And it had efficient processes and systems in place. The pharmacy had current electronic standard operating procedures (SOPs) which provided guidance for the team on how to carry out tasks correctly. The staff had read them. Members of the pharmacy team understood their roles well. They worked in accordance with the company's set procedures but in conjunction with the pharmacy manager, had also reviewed, suggested, and modified some of the ways they worked (as described below). 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.

The responsible pharmacist (RP) and staff had worked effectively together to implement several additional processes into their working routine when they dispensed prescriptions. This had made the pharmacy's internal systems safer. Staff processed electronic prescriptions in batches, on the first day, they were initially placed in date and time order. The team then picked the required medicines and placed each prescription along with the corresponding medicine(s) into colour coded baskets before putting them on designated shelves. Prescriptions were used to select medicines against. The team's practice of using baskets to hold prescriptions and medicines during the dispensing process helped prevent any inadvertent transfer between them. Each colour for the baskets indicated the day of the week that the prescription had been processed, and this was said to be the first accuracy check undertaken by staff. They also explained that on busier or more difficult days, the colour coded system visually helped the team to see which prescriptions were the oldest and needed checking first. The inspector observed that people's prescriptions were located quickly during the inspection.

The second accuracy check was described as taking place during the assembly process on day two. This area was checked daily. Staff explained that they ticked relevant details on each prescription when dispensing medicines. They ensured the person's name and details on generated dispensing labels matched the information on the prescription and ticked this along with the drug name, strength, form, and quantity as they made their accuracy-checks. This way, team members ensured a three-way check against the prescription, dispensing label and medicine took place during this process. There was also a facility on the dispensing labels which helped identify who had been involved in the dispensing process. Team members routinely used these as an audit trail.

Staff further explained that they circled prescriptions where people had the same name to help draw attention to this situation upon hand-out. Notes were made and placed on prescriptions as additional prompts so that the team knew which person had arrived to collect their medicines. Additional highlights were used for prescriptions with controlled drugs (CDs) where team members circled the

date on the prescription to help identify its 28-day expiry and wrote the words CD inside a triangle on the prescription itself. This was in addition to the stickers used (see Principle 4). These processes subsequently helped to easily identify every relevant detail. Members of the pharmacy team were also very organised, the inspector observed that they concentrated on one task at a time and ensured their workspaces as well as the pharmacy were kept tidy.

Once staff had checked prescriptions, they were moved to the accuracy-checking bench area for the RP to carry out the final check. After this, another accuracy-check of dispensed prescriptions 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. This was an effective audit trail. Four accuracy checks were said to take place for CDs.

The pharmacy team used a retrieval system to help track and manage stock. Once prescriptions were processed and stock ordered, notes were placed on the prescription to help identify which medicine(s) had been ordered. The box used to store these prescriptions was checked daily and before new prescriptions went into it. On the second day, staff described chasing stock that had been ordered automatically. Any medicines with stock issues were stored alphabetically, in a different box, and checked regularly. The RP explained that this system had helped reduce the pharmacy's stock levels which in turn, helped minimise mistakes occurring.

Staff routinely recorded mistakes that occurred during the dispensing process (near miss mistakes). The details were collated and regularly reviewed which helped identify any trends or patterns. The findings were subsequently discussed with the team to raise awareness and helped staff to learn from errors. The RP explained that near miss mistakes were reviewed with the team together every week to identify trends and staff reflected on errors themselves. Trends seen included for example, mistakes with dosages, slow-release formulations, and medicines which looked-alike and sounded-alike such as amlodipine and amitriptyline. The latter were also highlighted, separated, a list of them were displayed on the wall and staff wrote details on prescriptions to help further identify them. In addition, the RP explained that when he first started working at the pharmacy, he collaborated with the staff to improve the pharmacy's standards. This included reviewing the previous near miss records over the past year and a half, from which, he subsequently created a list of around 50 action points to help reduce the likelihood of similar errors recurring.

The RP's process to manage dispensing errors which reached people was also suitable and in line with the company's procedures. In addition, he ensured that all staff were involved and updated about incidents, extensive reflective accounts were then completed by team members which the inspector observed, took up a full A4 piece of paper when mistakes had been made. This further helped them to learn from the event. It was evident that the team consistently sought to learn from mistakes, that a culture of safety existed in this pharmacy and that the RP was very passionate about ensuring internal procedures were as safe as possible. This in turn, meant that services provided to people were delivered safely and effectively.

Staff had been trained to safeguard the welfare of vulnerable people and the RP was trained to level three. Team members could recognise signs of concerns and they knew who to refer to in the event of a concern. Contact details for the local safeguarding agencies were easily accessible and the pharmacy's chaperone policy was 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 had signed confidentiality clauses and received regular updates on data protection. Confidential information was stored and disposed of appropriately. Computer systems were password protected and staff used their own NHS smart cards to access electronic prescriptions.

The pharmacy's records were compliant with statutory and best practice requirements. This included the RP record, records of supplies made against private prescriptions, unlicensed medicines, emergency supplies, records to verify that fridge temperatures had remained within the required range and a sample of registers seen for controlled drugs (CDs). 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 were also complete and the pharmacy had suitable professional indemnity insurance arrangements in place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the appropriate skills, qualifications, and training to deliver the pharmacy’s services. Members of the pharmacy team are very experienced. They work well together. And the pharmacy as well as the regular pharmacist provide them with resources so that they can complete ongoing training. This keeps their skills and knowledge up to date.

Inspector's evidence

The inspector arrived shortly after the pharmacy opened. At this time, only the RP who was also the pharmacy manager and a pharmacy technician were present. People were observed to be served promptly and this situation was manageable. In total the pharmacy team consisted of four dispensing staff and two pharmacy technicians who were all part-time as well as a trainee ‘multi-skiller.’ This person worked in the store but could assist the team when needed on the counter. The RP explained that head office provided people in this role with a specific training pack, this arrangement was new, this member of staff was being supervised by the pharmacists and was in the process of reading the pharmacy’s SOPs. There were also two pharmacists who provided overlapping cover with contingency cover by locum pharmacists if needed. Staff wore name badges and uniforms. They were fully trained and very experienced, long-standing team members. Certificates to verify their qualifications were not seen but their competence was demonstrated. The pharmacy was largely up to date with the workload, team members confirmed that they had enough staff to suitably manage the workload and that they worked well as a team.

Staff knew which activities could take place in the absence of the RP and referred appropriately. They asked suitable questions through established sales of medicine protocols before selling medicines. Regular requests for medicines which could be abused were monitored and refused. Team members were provided with resources for ongoing training through the company’s online platform. This helped ensure they continually learnt and kept their knowledge up to date. In addition, the RP provided staff with additional ‘bite size’ training on various topical matters. He had also created a comprehensive training matrix which was regularly updated and on display to help highlight relevant training to be completed by team members and when this had been undertaken.

Staff communicated verbally, through a communications book, notes were left and via an electronic messaging application. There were also various noticeboards in the pharmacy with specific information on them, such as a designated noticeboard for safeguarding the welfare of vulnerable people, one for services and another highlighted safety information. Annual formal performance reviews took place. Targets for services involved asking at least two people every day about whether they would like a blood pressure check. Staff and the RP confirmed that all that was required was that they asked this question. There were no repercussions if this did not take place or if people did not use this service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable to provide healthcare. The pharmacy is clean and tidy. It is secure and presented appropriately.

Inspector's evidence

The pharmacy was situated at the back of the supermarket. The layout of the registered premises was somewhat challenging, but staff had made best use of the available space and shelving. The premises consisted of a small retail section and front counter, a relatively narrow dispensary lay behind this area and an extended storage section to one side which was used to store stock as well as a small area for the staff. This area was very organised with boxes which were clearly labelled and designated for specific stock. The lighting and ambient temperature within the pharmacy was appropriate for storing medicines and safe working. The dispensary was screened well which provided privacy when dispensing prescriptions. There was limited 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. 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. This room, however, was located behind the medicine counter and there was a sliding, plastic door from the dispensary into this room. This meant that there was a possibility that staff working directly in this area could potentially overhear conversations in the consultation room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively. The pharmacy sources its medicines from reputable suppliers. It stores and manages its medicines well. The pharmacy provides a range of useful services. Team members identify people requiring ongoing monitoring so that they can provide the appropriate advice. And the pharmacists regularly carry out interventions. This helps ensure people take their medicines correctly.

Inspector's evidence

Details about the pharmacy's services as well as its opening times were clearly advertised. People could enter the pharmacy through the supermarket's front doors which were powered and step free. The supermarket and area outside the pharmacy's retail area consisted of clear, open space and wide aisles. This helped people with restricted mobility or using wheelchairs to easily access the pharmacy's services. There were ample car parking spaces outside.

The pharmacists routinely provided advice, carried out interventions and offered useful services. Many interventions had been carried out with details regularly recorded that involved a range of issues. This included dosage checks, queries, over-the-counter case referrals, red flags, and where certain medicines, including CDs had been prescribed in excessive amounts. The outcome involved for example, people being counselled appropriately, and prescribed medicines subsequently being changed. People could have their blood pressure (BP) checked and their ambulatory BP could be monitored and checked over a 24-hour period through the pharmacy. The results were then sent to the GP surgery. The RP explained that this service had identified people with undiagnosed BP as well as other undiagnosed conditions such as atrial fibrillation.

The pharmacy also provided the Advanced NHS service, Pharmacy First. The service specification, SOPs, and Patient Group Directions (PGDs) to authorise this were readily accessible and had been signed by the RP. Suitable equipment was present which helped ensure that the service was provided safely and effectively (see Principle 5). The RP had also been trained on how to use them. The RP said that this service was manageable with overlapping cover, but that people's expectations required managing as they often believed that they could be supplied any medicine under this service.

Staff used stickers on assembled prescriptions to identify certain medicines or specific situations. This included fridge lines, CDs, if pharmacist intervention was required and for prescriptions with higher-risk medicines. Staff were said to remind the RP to routinely ask about relevant parameters. The pharmacy therefore consistently did this, and evidence was seen where details had been recorded to help verify this. The team also promoted information about higher-risk medicines to people who were unaware of relevant details. In addition, team members knew about the additional guidance when dispensing sodium valproate, topiramate and the associated Pregnancy Prevention Programme (PPP). These medicines were highlighted and separated. Staff ensured the relevant warning details on the packaging of sodium valproate were not covered when they placed the dispensing label on them and had identified people in the at-risk group who had been supplied this medicine.

The pharmacy's stock was stored in an organised way. Licensed wholesalers were used to obtain medicines and medical devices. The team checked medicines for expiry regularly and kept records of

when this had taken place and short-dated medicines were routinely identified. CDs were stored securely and the keys to the cabinet were maintained in a way which prevented unauthorised access. Fridge temperatures were checked daily. Records verifying this and that the temperature had remained within the required range had been appropriately completed. Dispensed CDs and temperature-sensitive medicines were stored within clear bags. This helped to easily identify the contents upon hand-out. Out- of-date and other waste medicines were separated before being collected by licensed waste collectors. Medicines which were returned to the pharmacy by people for disposal, were accepted by staff, and stored within designated containers in a specific, designated area. 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. Its equipment is clean. And the team ensures they are used appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had a suitable range of equipment and facilities. This included access to reference sources, clean, standardised conical measures for liquid medicines, tablet counting triangles, legally compliant CD cabinets and appropriately operating pharmacy fridge. The dispensary sink for reconstituting medicines was clean. The pharmacy had hot and cold running water available. The blood pressure machine and relevant equipment for the Pharmacy First Service were said to be new or recently replaced. This included an otoscope and tongue depressors. Computer terminals were positioned in a location that prevented unauthorised access. The pharmacy had cordless telephones so that private conversations could take place if required and confidential waste was suitably disposed of.

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.