General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Tesco Superstore, Viaduct Street, HUDDERSFIELD, West Yorkshire, HD1 1RW

Pharmacy reference: 1039626

Type of pharmacy: Community

Date of inspection: 29/04/2019

Pharmacy context

The pharmacy is in a supermarket in Huddersfield town centre. It is open 78 hours per week and open seven days a week. The pharmacy team mainly provide NHS dispensing and sell a range of over-the-counter medicines. And offer services including medicines use reviews (MUR), the NHS New Medicines Service (NMS), meningitis vaccinations via private patient group direction (PGD) and seasonal flu vaccinations via NHS and private PGD. They provide a substance misuse service, including supervised consumption to ten people, multi-compartmental compliance packs to approximately 40 people and head lice detection and treatment. And they provide treatment for erectile dysfunction and medicines to prevent malaria, both via private PGD. The pharmacy provides its services to a varied local population. It mainly receives prescriptions for repeat medication.

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 procedures to in place to identify and manage risks. It keeps them up to date. And it mostly maintains the pharmacy records it must by law. It regularly checks that the records it keeps for some medicines match what is in stock. But when the pharmacy team members find discrepancies, they don't always investigate properly. The pharmacy has systems in place to manage complaints and people can give feedback about its services. The pharmacy team members read and follow the procedures. They complete regular training. So, they know how to keep people's information secure. They understand how important their role is in keeping people's information safe. And, they know what to do if there is a concern about a vulnerable child or adult. They complete a regular audit of key governance and safety tasks. But, they don't always act when they identify areas for improvement. The team members regularly discuss mistakes that happen. They sometimes use this information to learn and make changes to help prevent similar mistakes happening again. But they don't always record their mistakes or analyse why they happen. So, they may miss opportunities to improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. It had reviewed the sample of procedures seen in 2018. And had scheduled the next review of the procedures for 2020. Pharmacy team members had read and signed the SOPs since the last review in 2018 to confirm they understood them. And clear version control information was displayed. The pharmacy defined the roles of the pharmacy team members in each procedure. The procedures showed who was able to perform each task. Pharmacy team members said they would ask the pharmacist if there was something felt unable to deal with. Pharmacy team members that did not work together communicated using a daily "Jobs to Do" list. They recorded tasks that needed to be completed. And the list was ticked when tasks had been completed. They placed completed lists in a communications book for future reference.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members were encouraged to record their own mistakes. But, it was usually the pharmacist that made the record. The pharmacy team discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. And there were very few records made. The manager advised there had been mistakes that had not been recorded. And he did not regularly analyse the data collected for patterns. The responsible pharmacist (RP) pharmacist explained the team had separated different strengths of sertraline after an error had been made. But, both strengths were being kept together during the inspection. The team gave other examples where changes had been made after an error. And, they had attached stickers to shelves in front of medicine that had been involved in a mistake to highlight the risks when dispensing. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using an electronic reporting system. And mistakes were reported to the superintendent pharmacist (SI). The pharmacy had a report of the most recent incident. The Pharmacy team had discussed the incident, which had involved someone fainting after a flu vaccination. The team had followed the correct procedure. But, in response to the incident, they had refreshed their knowledge about what to do if someone had a reaction to a vaccination. And the pharmacist had refreshed his knowledge of how to put someone in the recovery position.

The pharmacy team completed a Safe and Legal checklist each day. The checklist varied each day. And it

prompted the team to check various aspects of legal and operational compliance. For example, whether the controlled drugs (CD) cabinet was locked and the keys were being stored securely, whether confidential waste was being disposed of correctly and whether near miss errors were being recorded. The pharmacist signed-off the checklist each day. The team had recorded an issue they were having with a till terminal. They had recently reported it to the relevant department and the problem was still ongoing. But, the team had not raised the issue that near miss errors were not being recorded or properly monitored.

The RP said the most popular current service was providing meningitis vaccinations. The pharmacy had signed patient group direction (PGD) documents and declarations of competence in place for both pharmacists. The pharmacists renewed their training every year and up to date records were available. People were screened before receiving a vaccination by completing a questionnaire It asked then for information such as any allergies or medicines sensitivities, if they were taking any other medicines and their vaccination history. The pharmacist assessed the information provided and then gave a vaccination if appropriate. And they referred people who were unsuitable to receive a vaccination to their GP. The pharmacy kept a copy of each vaccination record. And they sent a copy to the person's GP for their records.

The pharmacy received a bulletin at least once a week called "Safety Starts Here". It told the team about any pharmacy or professional issues that had occurred elsewhere in the company. Pharmacy team members signed the bulletin to confirm they had read it. And they attached the latest bulletin to a noticeboard for everyone to see. There was a recent example available. It gave the team information about the recent changes to the legal classification of pregabalin and gabapentin.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. But, the pharmacist could not find any analysis information from the last set of questionnaires. She explained that people had given feedback about the condition and placement of the chairs in the waiting area. So, the pharmacy had replaced the chairs and moved them, so they were lass cramped.

The pharmacy had up to date professional indemnity insurance in place.

The pharmacy kept controlled drug (CD) registers complete. But, it did not complete page headers in some registers. It kept running balances in all registers. And they were audited against the physical stock quantity including, including methadone. But, the pharmacist had recently recorded three recent checks of methadone where they had found there to be less methadone in stock than expected. And, they had not investigated or provided any explanation for the loss. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy team monitored and recorded fridge temperatures daily. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen. The pharmacy kept private prescription and emergency supply records in a paper register and electronically. The records were complete and in order. But, there were some records in the paper register that were not kept electrically and vice versa. So, neither was a complete record.

The pharmacy kept sensitive information and materials in restricted areas. It positioned computer terminals away from public view. And they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. And, it collected confidential waste in red bags.

The bags were sealed when they were full. And they were sent to the store cash office for secure destruction. The pharmacy team had been trained to protect privacy and confidentiality. They completed mandatory training every year. The RP said there had been an assessment of the pharmacy to make sure it complied with the General Data Protection Regulations (GDPR). But she did not know if there had been any findings of the audit or if there were any records.

When asked about safeguarding, a dispenser some examples of symptoms that would raise her concerns in both children and adults. She explained how she would refer to the pharmacist. The pharmacist said she would assess the concern. And she would refer to the pharmacy manager or local safeguarding teams for advice. The pharmacy had contact details available for the local safeguarding service. The pharmacist completed training each year using the company's online training system. But, the pharmacy did not provide regular training to other members of team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. They reflect on their own performance. And discuss any training needs with the pharmacist. But, they don't complete regular planned training about pharmacy specific topics. So, it may be difficult to make sure their knowledge and skills are up to date. The pharmacy team members can discuss issues and act on ideas to support the delivery of services. But they don't always establish and discuss specific causes of mistakes. So, they may miss chances to learn from errors and make changes to make things safer.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist and a dispenser. The pharmacist manager was present for some of the inspection. The manager explained that there was always at least one dispenser working with the pharmacist when the pharmacy was open. But, he said most often there were two dispensers. On the morning of the inspection, one pharmacy team member was ill. The manager contacted other members of the team and arranged for one of them to cover the absence. Pharmacy team members completed mandatory compliance training every six months to one year, depending on the topic. The training covered things like health and safety, information governance and age restricted sales. They completed other learning, about pharmacy related subjects such as medicines and health conditions, ad-hoc by reading trade press material and discussing topics with colleagues.

The pharmacy had a yearly appraisal process. But the most recent appraisals had been delayed by the introduction of a new computer system. A dispenser explained that during an appraisal, she was able to discuss where she was doing well and where she could improve. And, she could identify any learning needs she had. She said one of her objectives from her last appraisal was to improve her customer service skills. She had been supported to reach her goal by training from the pharmacists and colleagues and by asking for feedback from people. And, after a period of learning and changes, she had received positive feedback from a patient and had received an award for good customer service.

A pharmacy team member explained they would raise professional concerns with the pharmacist, pharmacy manager, store manager or area manager. They said they felt comfortable raising a concern. And confident that their concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy in place and the team knew how to access the procedure.

The pharmacy team communicated with an open working dialogue during the inspection. The dispenser said they were told by the pharmacist when he had made a mistake. The discussion that followed did not fully explore why the mistake had been made. And they said they did not always record their mistakes. They said they weren't sure if they were always told about mistakes other people had made.

Pharmacy team members explained a change they had made after they had identified areas for improvement. The dispenser explained they had raised concerns about sometimes feeling overwhelmed by trying to remember tasks to be completed throughout the day. The team had discussed the concerns and had introduced a tasks list. They used the list to record any tasks that

needed to be completed by the dispensers throughout the day. The dispenser said the list had helped to prioritise work and to prevent jobs being missed. And it meant that all team members were clear about what had been done and what needed to be completed.

The pharmacy asked the team to meet targets in areas such as prescription volume, over the counter sales and the number of medicine use review (MUR) and New Medicines Service (NMS) consultations delivered. The pharmacy team said they did not feel under pressure to deliver targets. And they planned their services to help achieve targets set. The manager explained that if a target was not met, he would have a discussion with the area manager, who would suggest was the team could improve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately. But, it has limited space available to carry out prescription preparation. So, this might increase the risk of mistakes happening.

Inspector's evidence

The pharmacy was very small. And it had approximately four metres of bench space to use for all medicines preparation. But, the pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised, and the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. Equipment and stock were stored on shelves throughout the premises. And, baskets of dispensed medicines were stored on a holding shelf while they were waiting to be checked.

The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door. And the room was kept locked when it was not being used.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a WC elsewhere in the store, which provided a sink with cold running water and other facilities for hand washing.

The pharmacy maintained heat and light at acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined. And the pharmacy was well signposted from the rest of the store.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. And it generally provides its services safely and effectively. It stores, sources and manages medicines safely. But, the pharmacy team don't mark packs containing short-dated medicines. So, they may provide short-dated medicines to people. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines. And to identify what they look like. But, they don't regularly provide people with medicines information leaflets. So, people may not have correct information they need to help them take their medicines safely. The team takes steps to identify people taking high-risk medicines. And it provides them with some advice.

Inspector's evidence

The pharmacy was accessible via level access from the store car park through automatic doors. The pharmacy team could provide large-print labels and instruction sheets to people with visual impairment. And there was a hearing induction loop available for people with hearing impairment.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up and to organise the workflow.

The pharmacy supplied medicines in multi-compartmental compliance packs when requested. It provided descriptions of the medicines supplied on the packaging. But, it provided people with patient information leaflets about their medicines approximately every three months. The pharmacy team documented any changes to medicines provided in packs on the patient's master record sheet. But, they did not record any information about who had informed them of the changes or when. They used a tracker to keep records of when packs were supplied to people. The tracker was also used to record the number of packs supplied and who had dispensed and checked each one.

Pharmacy team members checked medicine expiry dates every three months. And records were seen. They recorded any short-dated items on a monthly stock expiry sheet at least six months before their expiry. And, removed the items the month before they were due to expire. But, they did not mark packs of short-dated medicines. So, they might not be noticed if someone picked them to dispense. The pharmacy responded to drug alerts and recalls immediately. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed.

The pharmacy obtained medicines from four licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs).

The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

The pharmacy used the computer system to highlight patients at risk when prescribed valproate. The pharmacy team alerted the pharmacist to relevant patients. The pharmacist explained they would ask each at-risk patient questions to make sure they were aware of the risks of the medicine during pregnancy. And whether they had adequate pregnancy prevention in place. The pharmacy had material available to give to people each time they received a supply. The pharmacy team asked people prescribed warfarin for their latest blood test results each time they handed in a prescription. The pharmacist checked the results provided and raised any concerns with the patient's warfarin clinic or GP. And, they checked that the patient was aware of their current dose and how many of each different strength tablet to take.

The pharmacy team were aware of the recent changes to the law under the Falsified Medicines Directive (FMD) to help identify counterfeit medicines. But, the pharmacy had not provided any equipment or software for the team to scan products. And, there were no procedures for the process and the team had not been trained.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The equipment available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation.

They used a separate set of measures to dispense methadone. The dispensary fridge was in good working order. And the team used it to store medicines only. Access to all equipment was restricted and all items were stored securely.

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.