General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Morning Lane, Hackney, LONDON, E9 6ND

Pharmacy reference: 1040104

Type of pharmacy: Community

Date of inspection: 18/01/2023

Pharmacy context

This is a supermarket pharmacy situated off a high street, serving the local population. In addition to dispensing medicines the pharmacy provides flu vaccinations. And it supplies people with medicines in multi-compartment compliance packs to help them manage their medicines.

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	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
2. Staff	Standards met	2.2	Good practice	Team members get time set aside for ongoing training and the pharmacy monitors their training.
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 to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. And team members understand their role in protecting vulnerable people.

Inspector's evidence

Standard operating procedures (SOPs) were available and up to date. SOPs were included as part of the team members' electronic learning modules. Team members had completed the training for SOPs relevant to their roles. The pharmacy manager signed off when team members had completed the training.

The team carried out checks daily using a handheld device, any issues found were reported to the store maintenance team. Checks were spilt into daily tasks and included confirming the RP records had been completed, if notices were displayed, and if the fridge temperature was monitored and recorded.

The pharmacy had processes to record dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were recorded in a book. Any next steps were discussed as a team. In some cases, individual team members were asked to mark medicine packs as they were checking to ensure that they were carrying out correct checks. After the near miss was recorded team members also put a star on a diagram identifying which area of the dispensing process the near miss had occurred this was the discussed with the team to try and identify why these mistakes were happening. The reviews had found that one of the main issues was rushing, and team members were all asked to slow down when dispensing. There was a process to follow when a dispensing error was reported. An incident report form was completed as well as a root cause analysis and next steps were discussed and recorded. A check was carried out after four weeks to ensure next steps had been implemented. The pharmacy had implemented a process whereby all team members carried out a third and fourth check on their own work before handing the medicines for a final check. This had reduced the number of dispensing errors. The team received 'Safety Starts Here' bulletins from the head office team. This contained shared learning from errors that may have occurred in other branches. There were also conference calls held monthly to share practices. The team recorded the number of days since the last error had occurred. Team members were all told that patient safety was at the forefront of everything they did and was relevant to everything including how stock was placed on shelves.

The correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and customer comment cards were handed out. The pharmacist tried to resolve issues in store where possible and there was a process for escalation. As a result of feedback, people were sent a message if they had requested a prescription and it had not been sent to the pharmacy from the surgery.

Records for private prescriptions, emergency supplies, unlicensed medicines, RP records and controlled

drug (CD) registers were well maintained. CDs that people had returned were recorded in a register as they were received. CD balance checks were completed at regular intervals.

Patient confidentiality was protected using a range of measures. Prescriptions awaiting collection were stored in the dispensary and were not visible to the public. Team members all completed annual training about information governance (IG). The IG policy was also renewed annually. Team members had individual smartcards to access NHS systems. Pharmacists had access to Summary Care Records and consent to access these was gained from people verbally. The pharmacy manager carried out monthly checks to make sure no one had looked at records which were not. Confidential waste was segregated in designated bins and left in an allocated secure area from where it was sent for destruction.

The team had completed safeguarding training on the online portal and the CPPE training course; in addition to this the pharmacists had also completed the level 3 safeguarding course. The team members would let the RP know if they had any concerns. Details were available for local safeguarding boards.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications, and training to deliver services safely and effectively. Team members get time set aside for ongoing structured training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the pharmacy manager and a trainee dispenser. The pharmacy manager said that there were an adequate number of team members for the services provided. He added he had not had any issues with arranging cover when team members were on leave. Team members counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment.

Individual performance and development were monitored by the pharmacy manager. Appraisal meetings were held annually with a process available for managing performance. Team members were also provided with on-the-spot feedback. Any informal conversations held were recorded.

Team members completing their formal training were given protected learning time to complete their work. The pharmacy manager was their supervisor. Ongoing training was completed on two separate online learning portals: 'Learning at Tesco' was used for pharmacy specific training and another portal was used for more generalised training. The pharmacy manager received a bulletin with details of what modules needed to be completed and was required to sign off training records for some training completed such as SOPs. Team members were able to ask the pharmacist questions. The trainee dispenser described that she had most recently completed training on salt and sugar content in food and the change in regulations regarding it. Team members also completed training for NHS services on eLearning for healthcare (eLfH), and had recently completed training on lung cancer and long-term coughs. Team members were provided with time to complete these during working hours.

Due to the shifts team members worked things were discussed as they came up, notes were made so that team members who were not working at the time could read these when they started their shifts. The pharmacy also received a Pharmacy Healthcare News bulletin from their head office team. All team members were required to read this and sign the document once they had completed it. Team members also communicated and shared information via a group chat on an electronic messaging application. There was an open working relationship in the team and team members felt that they were able to raise concerns to the pharmacists. Targets were set for services provided. The RP said there was no pressure to meet these and the targets did not affect his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was located at the front of a Tesco Superstore and was clearly signposted. Pharmacy-only (P) medicines were stored behind a small medicine counter. The dispensary was located to the side of the medicines counter and had sufficient work and storage space. Work benches were allocated for tasks and were clear and organised. Medicines were stored tidily medicines were stored in a tidy and organised manner inside drawers and on shelves. A clean sink was also available in the dispensary. Cleaning was carried out by team members and the store janitor the room temperature and lighting were adequate for the provision of healthcare. The premises were kept secure from unauthorised access.

A large clean signposted consultation room was available. The room allowed for conversations to be held inside which could not be overheard. Paperwork and records with people's private information were held in the room securely.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. It obtains its medicines from reputable sources, and it manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People with a range of needs can easily access the pharmacy's services.

Inspector's evidence

Consideration had been given to ensuring that pharmacy services were accessible to a range of people with different needs. There was step-free access into the store and wide automatic doors. A hearing loop was available. The team was able to produce large print labels. People were signposted to other services where appropriate and the team used either NHS websites or lists produced by the LPC. Services were advertised to people using leaflets and posters. Some team members were multilingual; colleagues from the supermarket were at times asked to translate, with customer consent. Team members also used translation applications. The RP explained that if someone did not speak English one of the pharmacists who was able to speak the same language as the person would provide services such as the New Medicine Service (NMS).

The RP felt the NHS Community Pharmacist Consultation Service (CPCS) had the most impact on the local population. People were referred to the service by their GPs. And as the pharmacy was open long hours people were able to obtain their urgent repeat medicines out of hours or at weekends.

The pharmacy had an established workflow. Colour-coded baskets were used as part of the dispensing process to separate prescriptions. Warning stickers were attached to some of the prescriptions by the RP during the checking process. Stickers were for where a person needed to be counselled by a pharmacist or if there was a fridge line or CD dispensed. It was very rare that the RP had to self-check as he did not work on his own. Dispensed and checked-by boxes on labels were initialled by members of the team to create an audit trail for the dispensing and checking processes. The pharmacist completing the clinical check annotated the prescription as did the team member who carried out a third check when handing out the prescription. Once prescriptions were checked by the pharmacist they were left in a designated area, where a team member would carry out a further accuracy check and then place the medicines in the bag. Pharmacists were always involved at the point of hand out of a prescription. As per company policy a further check was done at the point of handing out the prescription where the pharmacist removed all the medicines from the bag and checked these before handing them out. Prompts were stuck on the wall near the dispensing area to remind team members of what 'good' looked like and the process they should follow when dispensing prescriptions.

The pharmacist was aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). People in the at-risk group who were not part of the PPP were referred back to their prescriber. Team members confirmed that additional warning labels and cards were available if they weren't able to dispense the medicine in its original container. Team members had in the past completed training on dispensing sodium valproate and a poster was displayed in the dispensary to remind the team. Additional checks were carried out when people collected medicines which required ongoing monitoring. Stickers were attached to the prescriptions for these medicines which prompted team members to refer to the pharmacist to complete the checks.

The pharmacy did not have many people who collected warfarin.

Some people's medicines were supplied in multi-compartment compliance packs. People ordered prescriptions monthly which were automatically sent to the pharmacy. On receiving the prescriptions, a check was carried out against the electronic record for any changes or missing items. Team members contacted the surgery with any queries if there were any discrepancies. Records of checks carried out were not always made and the RP provided an assurance that in future any communication would be recorded. Dispensers prepared packs which were then checked by the pharmacist. On some occasions the pharmacy was not made aware if someone was admitted into hospital, but the pharmacy received discharge summaries when people were discharged. Assembled packs were labelled with product descriptions and mandatory warnings. Patient information leaflets (PILs) were handed out monthly and there was an audit trail to show who had prepared and checked the packs.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs. Fridge temperatures were monitored daily and recorded using the hand-held device. Team members were unsure as to how to bring up the report for previous temperature records. The fridge temperature was within the required range for the storage of medicines at the time of the inspection and the RP confirmed it had been in range previously.

Date checking was done every eight weeks. No date-expired medicines were observed on the shelves checked. A date-checking matrix was available and short-dated stock was marked. Out-of-date and other waste medicines were segregated and then collected by licensed waste collectors. Drug recalls were received electronically from head office, these were printed, actioned, signed and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had glass, crown stamped measures, and tablet counting equipment. Equipment was clean and ready for use. The pharmacy had a medical grade fridge of adequate size. Up-to-date reference sources were available including access to the internet. A blood pressure monitor was available. This was fairly new and had not yet been used and would be replaced by the head office team at regular intervals. The cholesterol and glucose testing devices for the health check service had been calibrated by the team on a weekly basis. However, the team had not provided this service since the start of the pandemic. The RP described how new monitors would be obtained when the service was relaunched. Computers were all password protected and screens faced away from people using the pharmacy.

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.