General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Instore Pharmacy, 230 High Road, South Tottenham, LONDON, N15 4AJ

Pharmacy reference: 1040441

Type of pharmacy: Community

Date of inspection: 18/07/2019

Pharmacy context

This community pharmacy is situated within a large superstore. It dispenses NHS prescriptions. And offers a minor ailments service and provides health checks such as blood pressure, glucose, and cholesterol testing.

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 training, training is monitored through regular conversations and any gaps in knowledge are identified.
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 generally identifies and manages the risks associated with its services. It largely keeps all the records it needs by law to ensure that its medicines are supplied safely and legally. And it asks people who use the pharmacy for their views. The pharmacy's team members understand their role in protecting vulnerable people. They undertake regular training to keep people's information safe. They record and review any mistakes they make when dispensing medicines to help prevent similar errors in the future.

Inspector's evidence

Standard operating procedures (SOPs) were in place and up to date. Team members had read SOPs relevant to their roles and training record cards were updated. Team roles were defined within the SOPs. The previous version of SOPS was stored in the dispensary with all the other folders. This could potentially cause confusion as to which SOPs were current.

Near misses were recorded in a log book by the person who made the error and a discussion was held with the responsible pharmacist (RP) about how the mistake and occurred and what the next steps were. Near misses were reviewed weekly. A poster was displayed near the workbenches prompting the team to check their work using mnemonics. The team were able to suggest ideas on how errors could be avoided. One of the dispensers had devised a warning box for paroxetine and pantoprazole as a result of a near miss. Warning signs were also attached to shelf edges. Reviews were discussed at the 'Team 5' meeting and key points were recorded on the board.

In the event that a dispensing incident was reported the RP would inform the area manager and discuss immediate next steps. A pharmacy incident report form (PIR) was completed on the Tesco internal system 'Comms Centre', a draft report was sent to the Regional Pharmacy Manager (RPM) to review. The initial form had a record of next steps to be taken suggested by the store. If after reviewing the form the RPM thought additional next steps needed to be taken, they would be suggested after which the form was submitted to head office. As a result of an error in which the wrong prescription was handed out to people with similar names. The pharmacy had ensured that separate baskets were used for all individuals including for family members and checking the bag label and prescription as well as confirming the information with the person collecting. The team had been asked to ensure they were not multi-tasking and the person who had dispensed the prescription was not to hand out the medicines. A note had also been made on the person's electronic record so it was flagged up at the point of dispensing and the address was highlighted on the bag label. The team member responsible had been asked to re-read and sign the SOP and was assessed after four weeks.

As part of the 'Safety Starts Here' bulletin the team looked at MHRA alerts, complaints, audits to be completed, and so on. Communication was received from head office on a monthly basis. The team discussed any incidents that had occurred in the branch, any safety measures that would be taken to avoid reoccurrence, and changes to legislation.

The pharmacy had a complaints procedure in place. And details of the customer services team were printed at the back of the receipts and posters were displayed with details of the complaint's procedure. Annual patient satisfaction surveys were also carried out. The RP would personally deal with the complaints and try to resolve these in store. Following feedback from someone that they had been

counselled on the use of their medicines at the counter in front of other people the RP had discussed with team to use the consultation room and offer it to people first before discussing anything. Information from incidents and complaints were shared on the team electronic messaging group chat. Complaints made directly to head office were discussed with the area manager.

The correct responsible pharmacist (RP) notice was displayed. 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.

RP records and controlled drug (CD) registers were well maintained. The pharmacy had not dispensed unlicensed specials for some time and did not have records available. The RP described the records that he would keep. Records for emergency supplies were generally well maintained but one of the entries observed did not have a reason for the supply recorded. Some of the records for private prescriptions did not have the correct date that the prescription had been issued. This could make it harder for the pharmacy to find out these details if there was a future query.

CD balance checks were carried out on a weekly basis. A random check of CD medicines complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received.

Patient confidentiality was protected using a range of measures. Prescriptions awaiting collection were stored in the dispensary and were not visible to the public. Members of staff had all been briefed on the information governance policy. The team had completed training on smartcard policy training and training on the General Data Protection Regulation on the Tesco Learning. 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 and recorded.

The team had completed safeguarding training on the Tesco Learning portal; in addition to this the RP had also completed the level 2 safeguarding course. The RP said that the team were in the process of renewing their training. The team would let the RP know if they had any concerns.

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

The pharmacy had recently changed their rotas following an analysis carried out by the head office team which had looked at dispensing data and till records. There was generally the RP plus one additional team member in the morning except accept Friday morning when there was no dispenser until 9.30am and there were two trained team members plus the RP in the evening. Saturday and Sundays there was generally the RP and one trained team member. At the time of the inspection the team comprised of the RP and two trained dispensers. A new member of staff started towards the end of the inspection and had been enrolled on the counter training course. The store also had four 'multiskillers' who worked in the main store but had completed some training and could support when needed.

The RP said that the team were stretched on occasions particularly when there was a larger delivery of stock into the pharmacy. The pharmacy was up to date with their dispensing. The team were able to manage their workload during the inspection and were observed to have an effective working relationship.

Staff performance was managed by the pharmacy manager with annual reviews carried out. The RP also gave team members immediate feedback. During the review a discussion was held as to how the team had performed as a whole and how the individual had played a part in this. One of the dispensers had raised that they had lost confidence in providing health checks during their appraisal and had been retrained. The RP said that he made time for team member's training and reviewed what they had done and how they were doing.

The dispenser asked appropriate questions before recommending treatment. She was also aware of the legal limits and age restrictions on the sale of certain medicines such as pseudoephedrine and would always refer to the pharmacist if unsure.

Team members were given training time during quiet periods or when there was an overlap. During this time, they completed online training modules which were available. The pharmacy manager updated the team with any information received via emails. The pharmacy also received the Healthcare Weekly News from head office. The team also held ‘Team 5’ meetings. A communication diary as well as a services diary (to follow up NMS and patient specific details) were also used. Members of the team were also part of a group chat on an electronic messaging application and shared learning via this. The team had discussed the change in guidance for dispensing sodium valproate during a ‘Team 5’ meeting as a result of which the caution label was made.

Ongoing training was completed on two online learning portals: ‘Tesco Academy’ and Click and Learn. The pharmacy manager received a bulletin with details of what modules needed to be completed. Modules included mandatory health and safety training as well as over-the-counter medicines, new

medicines and training for new services being launched such as the flu vaccination service. Each team member had a training record card which had a record of all the training they had completed including: Safe and Legal, safeguarding, bronze, and silver training. The date they had completed the training was signed by the pharmacy manager and counter signed by another pharmacist.

The pharmacy manager attended a weekly conference call and quarterly conferences for the area. The conferences covered different topics such as the Falsified Medicines Directive, company specific information and patient safety initiatives like look-alike sound-alike medicines (LASA). Different stores had discussed what they had done to identify LASA medicines. The pharmacy had used caution labels and large letters to highlight LASA medicines and had separate areas where the medicines were kept. On returning from the conference the pharmacy manager briefed the team and sometimes brought back material.There was an open working relationship in the team and team members felt that they were able to raise concerns to the pharmacists, store manager or higher management.

The team carried out Safe and Legal checks daily, 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.

Targets were in set for services offered. The pharmacist said that there was some pressure to meet these but patient safety would always come first and people would always be put first. The targets did not affect the RPs professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and they are kept secure.

Inspector's evidence

The pharmacy was reasonably clean; there was ample workspace which was labelled and allocated for certain tasks. A clean sink was also available in the dispensary and consultation room. Cleaning was carried out by the store janitor and team members. Medicines were arranged on shelves in a tidy and organised manner. The room temperature and lighting were adequate for the provision of healthcare. The store temperature was regulated. 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 would not be overheard. The room was locked when not in use. Paperwork and records with people's private information was held in the room in a cabinet; the RP said that people were not left unattended in the room. Entry into the dispensary was controlled via a door with a key lock. Prepared medicines were held securely in the dispensary out of the sight of people using the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally delivers its services in a safe and effective manner. It obtains its medicines from reputable sources. And it largely manages them appropriately so that they are safe for people to use. The pharmacy's team members are helpful, and they make sure people have all the information they need so that they can use their medication safely. The pharmacy takes the right action in response to safety alerts to protect people's health and wellbeing.

Inspector's evidence

Consideration had been given to ensuring that pharmacy services were accessible to all patients. There was step free access into the store with power assisted doors and there was a hearing loop available. The team was able to produce large print labels. People were signposted to other services where appropriate and the team used either the internet or a poster displayed behind the counter with details of local NHS walk-in centres, other pharmacies and other healthcare providers. The pharmacy team were multilingual but if a team member did not speak the language spoken by the person, the RP asked colleagues from the shop floor to help. The pharmacist also used a translator application on his mobile phone to help. Services were advertised to patients using leaflets, posters and were promoted on the instore tannoy system during flu and Hajj season and also online and in the Tesco magazines.

The RP said that the New Medicine Service had the most impact on people, due to the demography of the area many people were not aware of why they had been prescribed the medicines. The consultations allowed the pharmacists to ensure people were taking their medicines and counsel them if they had stopped taking the medicines due to side-effects. The RP gave examples of how he had counselled people on avoiding side-effects by doing simple things such as rinsing the mouth after using specific inhalers and taking some medicines after food. The RP had received feedback from people a few weeks later on the difference it had made. The pharmacist also used the opportunity to educate people especially those with diabetes and advised them that the pharmacy offered health-checks. The pharmacy had recently seen a spike in more people accessing this service. As part of the health check referrals were made if high results were obtained which could not be explained. People were provided with sheet to take to their GP.

The pharmacy had run an oral health campaign with the dentist situated next door. A stand with information and products specifically for children had been displayed near the pharmacy and the team had handed out leaflets. To ensure team members could answer questions the RP had asked them all to complete a training course on oral health. The RP said that representatives from Tottenham Hotspurs Football Club came in sometimes and provided free health checks in the store's foyer. Sometimes they then made referrals to the pharmacy or to GP.

The pharmacy had an established workflow in place. Many people dropped off their prescriptions and collected them after finishing their shopping. Prescriptions were taken in at the counter and left in a basket for the dispensers. Prescriptions were dispensed by the dispensers and checked by the RP.

Dispensed and checked by boxes were available on the labels; these were initialled by team members to help maintain an audit trail. The pharmacist completing the clinical check also annotated the prescription as did the team member who carried out a third check when handing out the prescription. The pharmacy team also used baskets for prescriptions to ensure that people's prescriptions were

separated and to reduce the risk of errors. Colour coded baskets were used for walk-in prescriptions to ensure these were prioritised.

Prescriptions for CDs including Schedule 4 were highlighted. Prescriptions were observed to be shown to the RP before being handed out.

The team were aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. An audit had been completed and findings were shared at the team meeting and on the group chat on an electronic messaging application. If someone in the at-risk group was not part of the Pregnancy Prevention Programme they would be referred back to their GP. A reminder had been attached on the shelfs prompting team members to check. The pharmacy did not have anyone who collected valproate who was part of the at-risk group. The team had the leaflets and warning cards which needed to be given out but did not have any warning stickers available. The RP said he would find out how to order more.

When high risk medicines such as warfarin were labelled, a warning prompt came up on the patient medication record. Dispensers printed and highlighted these and attached them to the basket and then on the bag. At handout the RP would check details of the person's INR and this was recorded on the patient medication record.

To manage the multi-compartment compliance pack service, the pharmacy used a book to record people's details and logged in when packs were due to be prepared and when they were due. Prescriptions for the multi-compartment compliance packs were ordered by the pharmacy. Once the prescription was received the packs were prepared. Prescriptions were checked for changes and the dispenser said the team tried to ensure the same brand was used each time. Each person enrolled on the service had their own labelled box which was used to store their medicines and individual records. Changes were queried with the person or the surgery and a note was made on the electronic record. The dispenser said that as there were so few people who were supplied their medicines on compliance packs the team had not had to deal with any hospital admissions.

There were no assembled packs available for inspection. The dispenser said that trays were labelled with labels generated using the electronic patient medication record system and product descriptions were included. Patient information leaflets were handed out monthly.

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; these were within the required range for the storage of medicines. CDs were kept securely.

Date checking was done on a quarterly basis with team members allocated sections. No date-expired medicines were observed on the shelves sampled. A date-checking matrix was in place. Short-dated stock was highlighted using a colour-coded dot system and a record was also made. Out-of-date and other waste medicines were segregated at the back and then collected by licensed waste collectors.

The pharmacy was not compliant with the Falsified Medicines Directive (FMD), the RP said that the company were working to launch a new operating system, and FMD was being trialled in two stores.

Drug recalls were received electronically from head office printed and filed. The last actioned alert was for phenobarbital and the pharmacy received the alert for Emerade during the inspection. Only employed pharmacists had access to the alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had a range of clean glass calibrated measures available. Tablet counting trays were available. A separate counter was used for cytotoxic medication to avoid contamination. The pharmacy had a blood pressure monitor, glucose and cholesterol monitors and a carbon monoxide monitor which were used as part of the services offered. The blood pressure monitor was replaced by head office. The cholesterol and glucose monitors were calibrated weekly in line with SOPs using a test solution. Calibration records were kept. Up-to-date reference sources were available including access to the internet. The pharmacy had a fridge of adequate size.

The pharmacy's computers were password protected and screens faced away from people using the pharmacy. Confidential paperwork and dispensing labels were collected in confidential waste bags.

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.