General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Surrey Quays, Redriff Road, Rotherhithe, LONDON, SE16 7LL

Pharmacy reference: 1040880

Type of pharmacy: Community

Date of inspection: 23/05/2019

Pharmacy context

This is a community pharmacy situated inside a large supermarket. It serves a mixed local population. The pharmacy sells a wide range of over-the-counter medicines and dispenses NHS prescriptions. It also supplies medicines in multi-compartment compliance trays and provides blood pressure and blood glucose 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	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 generally manages risks well to make sure people are kept safe. It records mistakes that occur during the dispensing process and learns from them. It also learns from mistakes that occur at other pharmacies. The pharmacy generally keeps the records it needs to by law. So, it can show that supplies are made safely and legally. It protects people's personal information. Team members are aware of how to protect vulnerable people.

Inspector's evidence

Stock was checked as soon as a prescription was received, and people were provided with an estimated waiting time. This helped the team manage its workload. A clinical check was first conducted by the pharmacist who initialled the left-hand corner of the prescription to confirm that a check had been conducted. Medicines were assembled by the technician or dispensers before a final accuracy check was conducted by the pharmacist. Medicines were confirmed with the person collecting them. Members of the team said that any changes, interactions or issues were highlighted to the pharmacist. Baskets were used throughout the dispensing process to prevent transfer of medicines between people's prescriptions.

The team were still referring to outdated standard operating procedures (SOPs) which should have been reviewed in July 2016. An updated version of the SOPs was available online and the pharmacist said he thought he had printed these out for the team, but he had in fact printed the older version. He said he would print the updated version and ask the team to read these. Roles and responsibilities were outlined within each SOP and members of the pharmacy team had signed training record sheets to confirm they had understood the relevant SOPs.

Near misses were seen to be recorded regularly. The pharmacist had recently briefed the team to record any near misses as soon as they were identified to ensure they were all captured. These were generally discussed with the team every week and 'next steps' were noted. For example, the team had separated Qvar Autohalers and aerosol inhalers in the drawers to help reduce picking errors. 'Look-alike and sound-alike' medicines, for example, allopurinol and amiodarone, carbamazepine and carbimazole, and metoclopramide and metoprolol were flagged up using shelf-edge labels.

There was a process in place to deal with dispensing errors. These were documented on an online form which was shared with the pharmacy's head office. The pharmacy team were briefed to highlight the formulation on the prescription following an incident where beclomethasone inhaler was supplied instead of beclomethasone nasal spray.

'Safety starts here' newsletters which were received from head office were seen to be signed by the team members to confirm they had read them. These newsletters highlighted errors or issues at other branches and any changes to be implemented by the team. A recent newsletter had highlighted valproate use in pregnancy.

An annual safety report was conducted by the pharmacist. This summarised errors, incidents, MHRA alerts and messages in the past year and what actions the team had taken.

In date indemnity and public liability insurance was in place. The responsible pharmacist (RP) sign was clearly displayed. Samples of the RP record were generally in order but there was some obliteration. The pharmacist said that they would use footnotes when making amendments to the record so that it would be clearer when the changes had been made. Emergency supply and private prescription records were held electronically. The nature of the emergency was not recorded for a number of entries checked. This could make it harder to find out what had happened if there was a query. The private prescription record was generally in order and 'specials' records were completed in line with MHRA requirements.
Samples of controlled drug (CD) registers examined were in order. CD running balance audits were conducted weekly; a random stock check of a CD agreed with the recorded balance. A destruction register was available to document CDs people had returned, but they were not always destroyed promptly. There was a large quantity of expired stock, taking up the entire bottom shelf of the CD cabinet. The pharmacist was advised to follow up with the Accountable Officer to arrange for their destruction.

Feedback was sought from people via annual questionnaires and cards referring them to online feedback forms. The pharmacy team said they made people aware of any stock supply issues and contacted their prescribers for alternative medicines.

A consultation room was available for private conversations and services. Computers were password protected and access to the patient medication record system was via individual smartcards. Confidential waste was stored in red waste bags which were collected daily by head office. Team members had read and signed the company's data protection policy as well as guidance on the General Data Protection Regulation.

All members of the team had completed Level two training on safeguarding vulnerable people. Members of the team were able to describe signs of abuse and neglect and said they would raise any safeguarding concerns with the pharmacist first.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members work in an open environment where they can make suggestions or raise concerns. But they do not always get time set aside to complete ongoing training. This may reduce the opportunities they have to help keep their skills and knowledge up to date.

Inspector's evidence

At the time of inspection there was a regular pharmacist (who was also the pharmacy manager), a technician and a dispenser. The pharmacy also employed another three part-time dispensers, two of whom were on long-term leave. There were also two 'multiskilled' colleagues who worked in the supermarket and were enrolled onto the counter assistant course.

Members of the team wore uniform and name badges. They had good rapport with people and managed their workload well throughout the inspection. They were observed communicating effectively together. The 'multi-skilled' colleagues covered the counter every now and then. Their main purpose was to cover annual and emergency leave.

Some members of the team felt the pharmacy was short-staffed as the dispensers who were on long-term leave had not been replaced. This made shifts difficult to cover and they said they were under some pressure when dispensing during busy periods. They felt this could potentially increase the chance of errors. Other members of the team said that the workload was manageable and that multi-skilled colleagues were being trained to support the team during busier periods.

The technician described her responsibilities which included housekeeping, downloading and dispensing electronic prescriptions, conducting CD balance audits, sorting deliveries and returns, conducting and delegating date checking tasks, as well as helping to train new members of the team. She also managed the minor ailment service, checking that it was being provided correctly by the team. She ensured that colleagues were following the procedure correctly in relation to the geographical area covered by the service and the items which could be supplied to people.

Protected study time was not routinely provided but the pharmacist asked members of the team to read and sign any new information or communications. The team had access to pharmacy magazines and booklets but said they took these home to read. The technician had brought her course booklets to share with the dispenser who was thinking of enrolling onto the technician course. The dispenser said she was keen to expand her knowledge and completed modules on the 'Tesco Academy' as and when she could.

Formal performance reviews were conducted annually. Members of the team said they were happy to raise concerns with the pharmacy manager and had opportunities to make suggestions during team meetings, which were held every now and then. They were aware of the whistleblowing policy. One member of the team had reported a pharmacist for stealing medicines. As a result, branches were asked to store certain products in a more secure place. Targets were set for members of the team who said they were not under pressure to meet them. They described the benefits of providing services to people.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, and the pharmacy provides a safe and secure environment for people to receive services.

Inspector's evidence

The pharmacy was located at the back of the supermarket and was clearly signposted. The dispensary was relatively small with limited work and storage space; there were two workbenches (each approximately five metres in length). The dispensary was clean and generally organised. But stock received from wholesalers was first placed on the workbenches which meant there was limited clear space to work on when deliveries were received. Members of the team said they would review the process for putting stock away to help ensure there was always clear space to dispense and check prescriptions.

A clean and spacious consultation room was available. The room was kept locked when not in use. The temperature was regulated by an air conditioning system and was suitable for the storage of medicines. There was good lighting throughout the premises. There was a clean sink available in the dispensary with hot and cold running water to allow for hand washing and preparation of medicines. Soap and hand sanitizer were available. The premises were secure.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy’s services. The pharmacy generally provides its services safely. But team members are not all aware of what advice to give people taking some higher-risk medicines. This could mean that people might not get all the information they need to take their medicines safely. The pharmacy generally manages medicines well to make sure that they are safe for people to use. And it takes the right action in response to safety alerts.

Inspector's evidence

Access into the supermarket was step-free and via wide automatic doors. There were two cushioned chairs in the waiting area for people wanting to wait for a service. Aisles were wide and there was ample space for people in wheelchairs or with pushchairs. A hearing loop was available for people with compatible hearing aids and the team had requested for the payment card machine to be lowered for people in wheelchairs. Services were advertised in the practice leaflet, on the company’s website and on a banner located behind the medicines counter.

The pharmacy was due to pilot a service with the local Clinical Commissioning Group and Nestle. This targeted diabetic people who were taking metformin and who may benefit from diet restrictions to help them manage their blood sugar levels. The pharmacy would complete a questionnaire with people and measure their average blood glucose levels (HbA1c) to assess if they were suitable for the service. People would then be assigned a nutritionist who was provided by Nestle and who they were able to contact 24 hours a day, seven days a week for advice. The pharmacy team would carry out follow-up consultations to check people’s compliance and provide advice on diet products available to purchase. The pharmacist had attended a training workshop and completed online training in order to provide the service.

Dispensing audit trails were maintained to help identify which members of the team were involved in clinically checking, dispensing and accuracy checking of prescriptions. Head office had reminded branches to conduct valproate audits in order to identify women in the ‘at-risk’ group. The pharmacy team had read the guidance, but some team members were not able to describe what checks they would make or what information to provide women in the ‘at-risk’ group. The pharmacy did not have the information cards or additional warning stickers to hand.

People taking warfarin were asked for their INR levels, but these were not always recorded for reference. Prescriptions for higher-risk medicines were not flagged up unless there was a change in the person’s medication. The pharmacist said he checked if people taking lithium were being monitored and provided advice on medicines to avoid, and the importance of attending their blood test appointments. He also encouraged people to read the patient information leaflets, so they were able to recognise signs of toxicity or side effects.

There was no system in place to highlight prescriptions for schedule 3 and 4 CDs to help reduce the chance of handing these out past the valid date on the prescription. The dispenser thought that prescriptions for a schedule 3 CD were valid for six months.

Stock was obtained from reputable wholesalers and was stored tidily on the shelves. Expiry date checks were conducted every three months and documented. Short-dated medicines were highlighted with a coloured sticker; no out-of-date medicines were found at the time of inspection. A small number of capsules had been removed from their original pack and stored in an amber medicine bottle. They were labelled with the batch number and expiry date but not the medicine's name and strength. This could make it harder for the team members to confirm which medicine it was. These were disposed of at the time of inspection.

The fridge temperatures were checked daily and kept within the required range of two to eight degrees Celsius. Drugs alerts and recalls were sent from head office via the intranet. These were printed out and signed. There was evidence that the pharmacy team had actioned recent 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 fridge was clean and suitable for the storage of medicines. Two clean, glass measures were available at the pharmacy. A new blood pressure monitor was in use; this was regularly replaced by head office. The CardioChek machine which was used to test blood glucose and cholesterol levels was tested with every new batch of test strips and cartridges. These tests were documented. Calibrations were also carried by an external company at least every six months.

The pharmacy had tablet and capsule counters, with a separately marked counting triangle used for cytotoxic medicines. Waste medicine bins and destruction kits were available to dispose of waste medicine and CDs respectively. These were stored securely. The team had access to the internet and up-to-date reference material.

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.