General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Tesco Superstore, Milton of Inshes, INVERNESS, Inverness-Shire, IV2 3TW

Pharmacy reference: 1042155

Type of pharmacy: Community

Date of inspection: 13/11/2019

Pharmacy context

The pharmacy is in a Tesco store on the edge of Inverness. It has long opening hours. And it opens on a Saturday and a Sunday. The pharmacy dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers a smoking cessation service and provides flu vaccinations.

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	Good practice	1.2	Good practice	The pharmacy embeds continuous improvement in its culture. The pharmacy team ensures it learns when things go wrong. And it takes its time to discuss and identify risks so that the safety and effectiveness of its services continue to improve.
		1.7	Good practice	The pharmacy has a systematic approach to information governance. It provides regular training. And it carries out regular reviews to confirm that its arrangements meet data protection requirements.
		1.8	Good practice	There is a clear culture of safeguarding the safety and wellbeing of children and vulnerable adults.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members complete regular training. And the pharmacy provides time during the working day to support them to do so.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy manages it services well. The pharmacy team members are organised and efficient. And they provide safe services.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

The pharmacy team members work to professional standards. And they keep good records about mistakes when they happen. The team members discuss the mistakes at regular meetings. And this helps them to make safety improvements to keep services safe. The pharmacy keeps the records it needs to by law. And it provides regular training for the team to keep confidential information safe. The team members understand their role in protecting vulnerable people. People using the pharmacy can raise concerns. And the pharmacy team members know to follow the company's complaints handling procedure. They listen to people and put things right when they can. And make service changes to improve people's experiences.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The team members had signed to confirm they followed the procedures. And to show they understood their roles and responsibilities. The pharmacy had displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The team members signed dispensing labels to show they had completed a dispensing task. And the pharmacist and the accuracy checking technician (ACT) provided feedback when dispensers failed to identify their own errors. The pharmacist sampled completed prescriptions to ensure that the pharmacy team were 'ticking' key information on the packs. And this provided assurance that all team members were carrying out accuracy checks. For example, checking the strength, formulation and expiry date. The team members were good at recording their own near-misses. And they provided reasons why they thought they had happened. The pharmacist analysed the data once a week. And the team members discussed the findings and agreed on new safety measures if they were needed. A sample review at the beginning of September 2019 showed that team members had agreed to use the HELP mnemonic. And the pharmacist had reminded them to take care when selecting look-alike and sound-alike medicines, such as naproxen and nitrofurantoin. The team members had recently introduced extra safety measures. And they had agreed to open prescription bags to carry out an extra accuracy check before they handed-out the medication. The pharmacy used an audit trail to record signatures at key points in the dispensing process. And a sample showed the team member who had completed the clinical check, the accuracy check and the check at the time it was handed out. This had been successful at identifying near-misses which they recorded.

The pharmacy used a safe and legal record to confirm that critical tasks were completed on time. For example, the team members checked that the responsible pharmacist record had been updated and the fridge temperature had been checked. The pharmacists managed the incident reporting process. And the pharmacy team members knew when incidents happened and what the cause had been. For example, they knew about a mix-up with pantoprazole and pravastatin. And that the pharmacist had attached a caution label to the shelf to highlight selection risks. The pharmacist used a large notice above the dispensing bench to show the pharmacy team members when the last dispensing incident had occurred. The pharmacy used a complaints policy. And this ensured that team members handled complaints in a consistent manner. The pharmacy did not display information to advise people how to complain or to provide feedback. But, the store encouraged people to provide feedback via its website. The pharmacist analysed the feedback. And had initiated a discussion with the

team members about the need to maintain positive interactions with people at the medicines counter even when they were feeling under pressure. And this had led to improvements in the feedback the pharmacy received.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy team kept the controlled drug registers up to date. And checked and verified the balance of the controlled drugs every week. This ensured that stock overages were accounted for and discrepancies identified and investigated. The pharmacy team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists had been accredited to use patient group directions to improve access to medicines and advice. And a sample trimethoprim patient group direction was valid until October 2020. The pharmacy had public liability and professional indemnity insurance in place and this was up to date.

The pharmacy displayed a notice which provided people with information about its data protection arrangements. The pharmacy trained team members on a regular basis to comply with data protection arrangements. And they knew how to safeguard personal information. The pharmacy disposed of confidential information in designated bags which were uplifted for off-site destruction. And it archived spent records for the standard retention period. The protecting vulnerable group (PVG) scheme was used to help protect children and vulnerable adults. And the company registered pharmacists onto the scheme. The pharmacy regularly trained its team members to follow its safeguarding arrangements. And it provided information, so they knew who to contact if they had a concern about a child or a vulnerable adult. The pharmacy team recognised the signs and symptoms of abuse and neglect. And knew when to refer to the pharmacist. For example, when someone known to experience poor mental health had presented with behavioural changes and an unkempt appearance.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably qualified pharmacy team members throughout the week. The pharmacy encourages the pharmacy team to develop. And it provides protected time in the work-place for them to learn. This ensures the team members keep up to date in their roles. The pharmacy team members support each other in their day-to-day work. And they speak up at regular meetings so that services continue to improve.

Inspector's evidence

The pharmacy had experienced a slight increase in the number of NHS prescription items it dispensed. And the pharmacist manager carried out regular reviews to confirm the pharmacy team still had the capacity and capability to provide its services. The team members did not feel undue pressure to achieve their performance targets. But, they were meeting their targets, such as registering a significant number of suitable people for the chronic medication service (CMS). Most of the team members had worked at the pharmacy for many years. And they were knowledgeable and experienced in their roles.

The pharmacist manager used rotas to ensure the pharmacy had the right number of suitably qualified team members on duty throughout the week. And the team members worked Monday to Sunday to provide service continuity. The pharmacist manager authorised annual leave. And only permitted one person to take leave at the one time. The pharmacy kept a locum guide on display. And it provided instructions about what to do in the absence of a pharmacist.

The pharmacy kept the team's training qualifications on-site. And the following team members were in post; one full-time pharmacist, one part-time pharmacist and locum pharmacists when required. One full-time pharmacy technician, one full-time trainee pharmacy technician, one part-time accuracy checking technician (ACT), one part-time trainee dispenser, three part-time dispensers, one new team member on induction, one part-time trainee medicines counter assistant (MCA) and one part-time driver. The pharmacists overlapped for two hours every Tuesday and Thursday to ensure they were up-to-date with routine tasks.

The pharmacist manager supported the team members to develop. And they allocated protected learning time so there was good progress with training courses. The company did not use individual performance reviews. But, it provided regular training to ensure that team members were competent in their roles. For example, they had been trained and accredited when necessary to provide services such as flu vaccinations. The pharmacy kept records of training that the team members completed. And they were up-to-date with the company's mandatory requirements. For example, they had completed safeguarding and information governance training in the last year. The company had provided training about a new Nytol liquid formulation. And a pharmaceutical company representative had provided training about inhaler devices, and another had provided training about nicotine replacement therapy.

The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had raised a concern with the area manager about congestion in the pharmacy. And having to use totes to keep prescriptions waiting to be collected. The area manager had taken photographs of the affected area. And the pharmacy team awaited feedback. The pharmacist had requested a new controlled drugs cabinet. And this had been agreed and ordered.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe and secure environment. And the team members keep the pharmacy clean and well-maintained. But, the team members do not always use the dispensing benches. And they sometimes put the dispensing baskets on the floor when they run out of space. This means they are unable to provide assurance that the benches are as clean as they need to be. The pharmacy has a consultation room that is professional in appearance. And it is an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. And the pharmacist supervised the medicines counter from the checking bench. The pharmacy had allocated areas and benches for the different dispensing tasks. But, the team members did not always use the benches. And they put dispensing baskets on the floor when they ran out of space. This created a contamination risk. And the risk of items falling from the shelves into the baskets and causing dispensing errors. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a consultation room. And this was professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know about its extended opening hours and the services that are available to them. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

The pharmacy had step-free access. And an automatic door provided unrestricted access for people with mobility difficulties. The pharmacy displayed its opening hours at the counter. And it displayed healthcare information leaflets at the waiting area and in the consultation room. The pharmacy provided information about its waiting times to manage people's expectations. And it informed people that the waiting time may be increased to allow the pharmacy team to carry out the checks it needed to. The dispensing benches were organised. And the pharmacy team members used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process. The pharmacist annotated prescriptions when he needed to speak to people about their medicines or when extra checks were needed. For example, for prescriptions with high risk medicines, or for new medicines.

The pharmacy provided flu vaccinations. And the pharmacist manager administered vaccinations in the other Tesco stores across the Highlands. The pharmacy dispensed serial prescriptions for around 200 people. And the registrations were mostly carried out by practice pharmacists at the surgeries. The prescriptions were kept separate. And the team members dispensed them around five days before they were due. And this managed the risk of having to make changes. A lead dispenser managed the process. And the team members used a ready reckoner to identify when prescriptions needed to be dispensed. The pharmacist monitored prescriptions to make sure people were taking their medicines as intended. For example, they had contacted the surgery when a prescription for six months' worth of clopidogrel had been issued. And they had arranged for a new prescription to be issued.

The pharmacy dispensed multi-compartment compliance packs for around 12 people. And the number of people registered had been capped due to space restrictions. The team members had read and signed the working instructions to ensure dispensing was safe and effective. A lead dispenser was responsible for dispensing the packs on a Sunday when it was quieter. And the rest of team had been trained and accredited trained to provide cover when needed. The team members used a tracker to ensure they carried out dispensing in time for the next supply. And they isolated packs when they were notified about prescription changes. The pharmacy supplied patient information leaflets and provided descriptions of medicines. And this supported people to take their medicines. The pharmacists dispensed methadone doses for around 20 people on the day they were due. And they carried out accuracy checks again as they supplied the doses.

The team members kept the pharmacy shelves neat and tidy. And they purchased medicines and medical devices from recognised suppliers. The team members kept controlled drugs in two organised

cabinets to manage selection risks. For example, they kept expired stock and returned medication separate. The pharmacy team members carried out regular stock management activities. And highlighted short dated stock and part-packs during regular checks. The team members monitored and recorded the fridge temperature. And demonstrated that the temperature had remained between two and eight degrees Celsius.

The pharmacy accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected. The pharmacy team acted on drug alerts and recalls. And recorded the outcome, and the date they checked for affected stock. For example, they had checked for omeprazole powder in July 2019 with no stock found. The pharmacy team members had been briefed about the valproate pregnancy protection programme. And they knew where to find the safety cards and when to issue them. The pharmacist monitored prescriptions for valproate. And knew to check that people had received safety information about the risks associated with taking valproate. The pharmacy had not implemented the Falsified Medicines Directive (FMD). The team members knew about the directive. But they did not know when it was due to be implemented.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And the pharmacy team members keep the equipment clean and maintained.

Inspector's evidence

The pharmacy had access to a range of up to date reference sources, including the British National Formulary (BNF). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. And the team members had highlighted the measures only to be used for methadone. The pharmacy used a blood pressure monitor. And the pharmacist confirmed it had been renewed in April 2019. But they could not produce evidence to show this.

The pharmacy provided cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members used a portable phone. And they took calls in private when necessary.

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.