General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Terra Nova Way, Western Road, PENARTH, South Glamorgan, CF64 1SA

Pharmacy reference: 1043729

Type of pharmacy: Community

Date of inspection: 11/12/2019

Pharmacy context

This is a pharmacy set inside a large supermarket in a town centre. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a range of services including emergency hormonal contraception, treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients. Substance misuse services are also available. Most people who use the pharmacy do so while they are shopping in the supermarket.

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 has written procedures to help make sure the team works safely. Its team members generally record and review their mistakes so they can learn from them. And they take action to help stop mistakes from happening again. The pharmacy generally keeps the records it needs to by law. But some details are missing, so it may not always be able to show exactly what has happened if any problems arise. It asks people to give their views about the services it provides. And it keeps people's private information safe. The pharmacy's team members understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had systems in place to identify and manage risk, including the recording and analysis of dispensing errors and near misses. However, no near misses had been recorded for the current month and it was likely that some incidents had not been captured. The pharmacist manager said that he reviewed near misses on a weekly basis and documented any actions to be taken if he discovered a pattern or trend. Some action had been taken to reduce risks that had been identified: for example, caution stickers had been used to alert staff to the risks of picking errors with amlodipine and amitriptyline, different forms of Epilim and different strengths of canaglifozin after some near misses. Staff demonstrated that methotrexate 2.5mg tablets were now stored separately in a basket at the direction of the superintendent's office following an incident in another branch. The running balance of these tablets was checked weekly. A safety bulletin produced by the superintendent's office about the risks associated with methotrexate was displayed on the dispensary noticeboard. The pharmacist explained that the pharmacy no longer stocked methotrexate 10mg tablets in line with company policy. Regular team meetings were held to discuss patient safety issues, such as risks with similar packaging and new products. Following a discussion about a quantity error that had occurred with a controlled drug, the team had decided to mark split boxes on all sides to help ensure they were not mistaken for original packs. Discussions were documented and had been signed by all staff.

A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. A list of weekly, monthly and quarterly tasks was displayed on the dispensary noticeboard, as was the SOP to be followed in the absence of a responsible pharmacist. The responsible pharmacist notice displayed was correct at the beginning of the inspection but was not changed when the pharmacist manager took over the running of the pharmacy at 2pm. He remedied this as soon as it was pointed out.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed on the dispensary noticeboard showed that this was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet displayed in the retail area.

Evidence of professional indemnity insurance was available. All necessary records were kept and were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were checked weekly. However, there were occasions on which a pharmacist had not signed out of the RP register to show the time at which they had relinquished responsibility for the safe and effective running of the

pharmacy. Alterations made to the RP register were not always accompanied by a clear audit trail. Electronic emergency supply records were not always made in line with legal requirements. Some did not include the nature of the emergency and some were recorded as having been made at the request of the prescriber when they appeared to have been made at the request of the patient. Some headings in the methadone registers were missing and some were incorrect. The pharmacist remedied this immediately. There was a risk that records held might not include enough correct information to allow the pharmacy team to fully resolve queries or deal with errors effectively.

Staff had signed confidentiality agreements. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. Individual staff members had unique passwords to access the pharmacy software system.

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details that were available in the dispensary. Staff had received in-house training and were able to identify different types of safeguarding concerns. They said that they would refer these to the pharmacists, who confirmed that they would report concerns via the appropriate channels where necessary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are properly trained for the jobs they do. They have a good understanding about their roles and responsibilities. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The regular pharmacist manager worked at the pharmacy on most days, assisted by two regular part-time pharmacists. A regular locum pharmacist worked on Saturday evenings. Two pharmacists were available at the pharmacy for about two hours every weekday afternoon. The support team consisted of a trainee pharmacy technician, two dispensing assistants and a trainee dispensing assistant. Another trainee pharmacy technician and a dispensing assistant were absent. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. Staff members had the necessary training and qualifications for their roles. Trainee staff worked under the pharmacists' supervision.

Targets were set for MURs but these were managed appropriately and the pharmacists said that they did not affect their professional judgement or compromise patient care. Staff worked well together and said that they were happy to make suggestions within the team. They said that they felt comfortable raising concerns with the pharmacists, Area Manager and staff from the superintendent's office. A poster advertising a confidential helpline for reporting concerns was displayed on the dispensary noticeboard.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients and referred to the pharmacist on several occasions for further advice on how to deal with a transaction. The pharmacist said that although the organisation had previously provided a structured online training programme, this was not currently in use. Staff had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They said that much of their learning was via informal discussions with the pharmacists and from regular bulletins provided by head office. The lack of a structured training programme might restrict the ability of individuals to keep up to date with current pharmacy practice. All staff were subject to annual performance and development reviews. They could informally discuss issues with the pharmacists whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and secure. It has enough space to allow safe working and its layout protects people’s privacy.

Inspector's evidence

The pharmacy was clean, tidy and well-organised, with enough space to allow safe working. Some stock and dispensed prescriptions awaiting collection were temporarily stored on the floor but did not pose a trip hazard. The sinks had hot and cold running water and soap and cleaning materials were available. Staff said that a cleaner employed by the company cleaned the floor twice weekly during pharmacy opening hours. A consultation room was available for private consultations and counselling and its availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy for people to access. If it can't provide a service, it directs people to somewhere that can help. The pharmacy's working practices are safe and effective. It stores medicines appropriately and carries out some checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. A hearing aid loop was available at the medicines counter. Staff said that they would signpost people requesting services they could not provide to other nearby pharmacies.

Dispensing staff used a colour-coded basket system to help ensure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Dispensing labels were initialled by the dispenser and checker to provide an audit trail and the pharmacist performed a third check on all prescription items at the handout stage. This third check alerted the pharmacist to any Schedule 3 and 4 CDs awaiting collection and ensured that these prescriptions were checked for validity before supply to the patient or their representative. The pharmacists said that the third check also allowed them to identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate for counselling. They said that they sometimes recorded information about blood tests and dosage changes for these patients on the patient medication record (PMR) as part of an MUR.

Controlled drugs (CDs) requiring safe custody and fridge lines were not usually dispensed until the patient or their representative came to collect them. An owing note or dispensing label was attached to the prescription to alert staff to the fact that a CD or fridge item was outstanding. Prescriptions awaiting collection were annotated to identify patients eligible for an MUR. The patient's age and date of birth were highlighted on prescriptions for children under 12 to alert staff to the risks associated with paediatric medicines.

The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that one patient prescribed valproate who met the risk criteria had been counselled and provided with appropriate information, which was available in the dispensary. The pharmacy carried out regular high-risk medicines audits commissioned by the local health board. These audits were used to collect data about the prescribing, supply and record-keeping associated with high-risk medicines to flag up areas where risk reduction could be improved within primary care.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a number of patients. The compliance aids were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. A list of patients was displayed in the dispensary for reference. Names on the list were flagged if staff were aware the patient was in hospital. Each patient had a section in a dedicated file that included their personal and medication details, collection arrangements, details of any messages or changes and any relevant documentation, such as discharge summaries.

The pharmacy had carried out approximately 1000 influenza vaccinations during the 2019/20 season. The pharmacist said that these had been split evenly between the private and NHS enhanced services. He said that there was also a high demand for the health board-commissioned Emergency Supply of Prescribed Medicines service. Clients of the substance misuse service were allocated a section in a dedicated file which included their personal details, current prescription and signed contract if supervised.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were stored in two well-organised drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in two well-organised CD cabinets and obsolete CDs were segregated from usable stock.

Stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug alerts and recalls via email. The pharmacist was able to describe how he would deal with medicines or medical devices that had been recalled as unfit for purpose by contacting patients where necessary, quarantining affected stock and returning it to the supplier. Drug recalls were printed, filed and signed to show that they had been actioned. The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive but the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It generally makes sure these are safe and suitable for use. The pharmacy's team members use equipment and facilities in a way that protects people's privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Separate measures were used for methadone. Triangles and capsule counters were used to count tablets and capsules. These were dusty and staff said that they would be washed before use. A separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. Most equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. The fax machine did not work, but the pharmacist said that the local GP surgeries were aware of this and contacted the pharmacy by telephone and e-mail rather than by fax. He said that the out-of-hours GP service did not use the pharmacy as they were aware that they could not fax prescriptions to them. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the pharmacy software system was protected with a password and the consultation room was used for private consultations and counselling.

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.