General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Brunton Lane, Kingston Park, NEWCASTLE UPON TYNE, Tyne and Wear, NE3 2FP

Pharmacy reference: 1081573

Type of pharmacy: Community

Date of inspection: 19/03/2024

Pharmacy context

This is a pharmacy in a large supermarket in a retail park in Newcastle. Its main activity is dispensing NHS prescriptions. It provides some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. It provides a range of NHS services including Pharmacy First and the hypertension case finding service.

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's written procedures help manage risk so that team members can provide services safely and effectively. Team members record mistakes made during the dispensing process and make changes to help prevent the same or a similar mistake occurring. They keep the records required by law and know to keep people's private information secure. They know how to respond to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. They included SOPs about the responsible pharmacist (RP), controlled drug (CD) management and dispensing activities. These were reviewed by the company's superintendent (SI) pharmacist team every two years with the last review completed in July 2023. Team members accessed them on an electronic platform and were alerted when there were new SOPs to read. Team members signed online to confirm they had understood the SOPs. The pharmacist manager and head office teams checked that updated SOPs were actioned in a timely manner.

The pharmacy recorded mistakes identified and rectified during the dispensing process, known as near misses. The team member responsible for the near miss recorded the details about it and why it had happened when identified by the pharmacist. The pharmacists had informal conversations with team members about the near misses. Team members had highlighted areas in the dispensary where medicines that looked-alike or sounded-alike were kept, alerting the dispenser to take extra care when selecting these medicines. The pharmacy completed incident reports for mistakes that were not identified until after a person had received their medicine, known as dispensing errors. These were recorded online and shared with the company's head office. Team members had a procedure for dealing with complaints. They aimed to resolve any complaints or concerns locally and completed an incident report. If they were unable to resolve the complaint, they escalated it to the regional manager. People could also submit complaints or concerns directly to the company's customer care team.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. And they knew which tasks could and could not take place in the absence of the RP. The RP notice was prominently displayed on the medicines counter and reflected the details of the RP on duty. The RP record was completed correctly. The pharmacy recorded the receipt and supply of its CDs. The entries checked were in order, with some minor omissions of the address of the supplying wholesaler. Team members checked the physical stock levels of medicines matched those in the CD register on a weekly basis. The pharmacy kept certificates of conformity for unlicensed medicines and full details of the supplies were kept to provide an audit trail. It kept complete electronic records for supplies of medicines made against private prescriptions and retained the corresponding prescriptions. And for emergency-supplied medicines, the reason for the supply was recorded.

Team members received annual training about information governance and the General Data Protection Regulation. The pharmacy kept confidential waste separately for destruction. Team members received formal training about safeguarding every two years. And they knew to refer any concerns to the pharmacist. The pharmacists had completed level three safeguarding training and would access contact details for relevant authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably qualified or in training team members to help manage its workload safely. Pharmacists complete appropriate training for the services they provide. Team members ask suitable questions and give appropriate advice when assisting people with their healthcare needs.

Inspector's evidence

At the time of the inspection the RP was the pharmacist manager, and they were supported by a pharmacy technician and a trainee dispenser. Another pharmacist was also present, and a third pharmacist started their shift towards the end of the inspection. Other team members not present were a further part-time pharmacist, three trained dispensers and two trainee dispensers. Two pharmacists covered the extended opening hours each day and there was approximately 12 hours of pharmacist overlap per week.

Team members had either completed accredited training or were completing accredited training for their roles. Those in training received protected learning time to complete their training in a timely manner. And their training was overseen by one of the part-time pharmacists. The pharmacists had completed training with the Centre for Pharmacy Postgraduate Education and company-provided training for the newly launched NHS Pharmacy First service, which included training in the use of an otoscope. One pharmacist was still in the process of reading the patient group directions (PGDs) for the Pharmacy First service so they were able to provide it. The other pharmacists had already read and signed the corresponding PGDs. Team members received a weekly newsletter from the company with communications and learnings from other pharmacies in the company.

Team members were observed supporting each other to manage the workload. Annual leave was planned in advance and part-time team members could increase their hours to support periods of absence. If required, team members from other pharmacies in the company could also support periods of absence. Team members received annual performance reviews and the pharmacist manager was due to begin the reviews in the next month. There was an open and honest culture amongst the team, and they felt comfortable to raise concerns with management if required. Team members were set targets by the company but did not feel under pressure to achieve them.

Team members asked appropriate questions when selling medicines over the counter. They knew to be vigilant about repeated requests for medicines liable to misuse, for example medicines containing codeine, and referred such requests to the pharmacist. And the pharmacist would have supportive conversations with people or refer them to their GP.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, secure and suitable for the services it provides. It has suitable facilities for people requiring privacy when accessing the pharmacy’s services.

Inspector's evidence

The pharmacy was positioned to the rear of the supermarket. It had a medicines counter which acted as a barrier to prevent unauthorised access to the dispensary. The dispensary was small but was well laid out and organised. Team members managed the limited space well and there were different bench spaces for team members to work and compete different tasks. The pharmacist’s checking bench allowed for effective supervision of the dispensary and medicines counter. And pharmacists were able to intervene in conversations at the medicines counter if necessary. Medicines were stored neatly on shelves and the dispensary was tidy. Team members knew to raise any issues with the maintenance team. They reported having recently lost electricity in the consultation room due to ongoing works in the supermarket and this had been resolved. The main dispensary had a sink which provided hot and cold water for handwashing and professional use. There were toilets which provided separate facilities for hand washing. The temperature was comfortable throughout and the lighting was bright.

The pharmacy had a lockable soundproofed room adjacent to the dispensary where people could have private conversations with team members and access services. This consultation room was spacious and had a desk, two chairs and a computer. There was a sink which provided hot and cold water. The room was kept locked when not in use. There was also a small area outside the consultation room for people to wait which included chairs that could be easily cleaned.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively. And it makes them accessible to people. The pharmacy generally provides people with the necessary information to help them take their medicines safely. Team members complete checks on medicines to ensure they remain fit for supply. And they respond appropriately when they receive alerts about the safety of medicines.

Inspector's evidence

The supermarket had automatic doors from the car park which provided ease of access to those using wheelchairs or with prams. The supermarket was large, and the pharmacy was positioned to the rear, but it was accessible. There was a hearing loop positioned on the medicines counter for some people with hearing difficulties. The pharmacy displayed healthcare leaflets for people to read or take away including a pharmacy practice leaflet which informed people of the services the pharmacy provided. The NHS Pharmacy First service was underpinned by PGDs which were available in paper form for easy referencing and had been signed by the pharmacists.

Team members used baskets to keep people's prescriptions and medicines together and prevent them becoming mixed-up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members highlighted the inclusion of a CD or fridge line on a prescription and had laminates to attach to prescriptions for high-risk medicines such as valproate and methotrexate. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicine safely. They were aware of the requirement for issuing valproate in original packs as per recently updated legislation. Team members confirmed they supplied valproate to someone in the at-risk category and pharmacists had counselled the person to ensure they had received an annual review with their GP. Team members also confirmed they supplied valproate in a multi-compartment compliance pack to someone, but no formal risk assessment had been completed for supplying the person with their valproate in this way. They had however assessed this as being the most appropriate way in which the person should receive the medicine. Team members were observed making suitable checks when handing out medicines to people to ensure they were given to the correct person. And they completed a "third bag check" which involved opening the medicine bag and completing a check on all the items in the bag.

The pharmacy supervised the administration of medicine to some people. Team members managed the service by preparing the medicine on a daily basis before they were due. The doses were prepared by a dispenser and double checked by a pharmacist. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. Each team member was responsible for a small number of the compliance packs. Each person had a medication record sheet which documented the medicines and dosage times. Team members received communications about changes to people's packs and these were kept with the person's medication record. Team members provided descriptions and warnings of the medicines in the pack, so people had information to take their medicines safely. The pharmacist confirmed that patient information leaflets (PILs) had been supplied to people previously and were now only supplied if there was a new medicine. This could mean people don't have up-to-date information about all the medicines they take.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were

stored behind the medicines counter which helped ensure the sales of these medicines were supervised by the pharmacist. Team members had a process for checking the expiry dates of medicines. Each team member was responsible for a particular area of the dispensary and date checking was completed by each team member monthly. Medicines that were going out of date in the next six months were highlighted for use first and were written in a notebook to be removed the month before they expired. A random selection of 15 medicines found none were out of date. And team members completed date checking as part of their dispensing and checking processes. The pharmacy had one fridge. Team members recorded the temperatures daily as part of compliance checks for the entire store. Records showed that the fridge was operating between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls directly from the company on an online platform or via NHS mail. These were printed and signed to say what action had been taken. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to up-to-date electronic reference sources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had a blood pressure monitor and ambulatory blood pressure monitor used in the hypertension case finding service. The pharmacist confirmed the blood pressure monitor was first in use six months previously and the ambulatory monitor was first in use in the last year. And it was cleaned when it was returned by people. The pharmacy had equipment used in the NHS Pharmacy First service including an otoscope, tongue depressors, a pulse oximeter and a thermometer. For its seasonal vaccination services, it had in-date adrenaline ampoules and pens for use in an emergency. The pharmacy had crown stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines awaiting collection away from public view to protect people's private information. Confidential information was secured on computers using passwords, and NHS smartcards were in use. Screens were positioned in the dispensary and consultation room in a way that prevented unauthorised access to confidential information.

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.