General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Bradford Road, BATLEY, West Yorkshire, WF17 5TJ

Pharmacy reference: 1092449

Type of pharmacy: Community

Date of inspection: 14/11/2019

Pharmacy context

This is a community pharmacy in a Tesco supermarket in the town of Batley, West Yorkshire. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including seasonal flu vaccinations, the NHS new medicines service (NMS) and medicines use reviews (MURs). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

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 identifies and manages the risks associated with the services it provides to people. And it has a set of up-to-date written procedures for the team members to follow to help them deliver the services safely. It keeps the records it must have by law. And it keeps people's private information secure. The team members discuss and record any mistakes that they make when dispensing. So, they can learn from each other. And they implement changes to minimise the risk of similar mistakes happening in the future. The team members know when, and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy was located at the rear of the supermarket. The pharmacy was busy at the time of the inspection with several people leaving their prescriptions to be dispensed by the pharmacy team while they did their shopping in other areas of the supermarket. The pharmacists completed their final checks of prescriptions in a part of the dispensary that was close to the pharmacy counter. This allowed the pharmacist to listen to conversations between the team members and people who wanted advice or to purchase an over-the-counter product. And to intervene if necessary.

The pharmacy had a set of written standard operating procedures (SOPs). They included ones for responsible pharmacist (RP) regulations and dispensing. There was an index available but many of the SOPs were not kept in order. And so, it was difficult to find a specific SOP. The superintendent pharmacist's team reviewed each SOP every two years. This ensured that they were up-to-date. The pharmacy defined the roles of the pharmacy team members in each SOP. They described how they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with.

The pharmacy recorded near miss errors made while dispensing onto a paper near miss log. The errors were typically spotted by the pharmacist completing the final check. The team member who made the error was responsible for entering the details of the error into the log. The team members explained this helped them take ownership and responsibility for their errors and helped with their learning. The details recorded included the time and date of the error and the reason the error might have happened. But the reasons were often non-specific, for example, on many of the records seen, the error was because of 'rushing' or the pharmacy being 'busy'. The regular pharmacist explained he had recently told the team to be open and honest if they felt they were tired or working under pressure. If they felt they were tired, he asked them to take a 5-minute walk around the supermarket. He said this helped the team member take a mental break from the dispensing process and come back to work with a higher level of concentration. The pharmacy completed an analysis of the errors that had been recorded each month. This was to identify any trends or patterns. And the findings were discussed with the team when most of the team members were working. Those team members who were not working, were informed of the findings when they next attended for work. The pharmacist explained she had noticed a series of selection errors with medicines that looked or sounded similar, known as LASA medicines. The team members discussed the errors in a monthly meeting and considered the steps they could take to prevent similar errors happening again. For example, they attached hazard warning stickers to shelf edges where the pharmacy stored amlodipine. This reminded them of the potential for mistakes with these medicines. They also stored amitriptyline with 'S' medicines rather than with 'A' medicines. This was to reduce the risk of amitriptyline being mixed up with amlodipine. The pharmacy

recorded dispensing errors which had reached the patient on an electronic reporting system. And the details of each error were sent to the pharmacy's regional manager and superintendent pharmacist's office. The pharmacy outlined what they intended to do to prevent a similar error happen again. And these actions were then analysed by the regional manager.

The pharmacy did not advertise how people could make comments, suggestions and complaints. It collected feedback from people through verbal conversations and mystery shopper visits. The team members could not give any examples of changes made to improve services following any feedback they had received from people.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of MST 10mg tablets matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team members were aware of the need to keep people's personal information confidential. And they were seen offering the use of the consultation room to people to discuss their health in private. They had all undertaken general data protection regulation (GDPR) training. The team held records containing personal identifiable information in areas of the pharmacy that only the team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor.

The regular pharmacist had completed training on safeguarding the welfare of vulnerable adults and children up to level 2, via the Centre for Pharmacy Postgraduate Education (CPPE). The team members gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload and to ensure people receive a high-quality service. The pharmacy team members complete training to keep their knowledge and skills up to date. And they are provided with annual appraisals to discuss their performance and training needs. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection the regular pharmacist was working alongside a locum pharmacist. And they were supported by three part-time pharmacy assistants. The pharmacy also employed a second pharmacist and two other part-time pharmacy assistants. The pharmacist hours were split between the pharmacist present during the inspection and the second pharmacist. But they worked together for two hours every day. This allowed them to complete various other tasks such as basic administration, and to provide services such as medicine use reviews. The pharmacy organised the team rotas in advance to ensure enough support was available during the pharmacy's busiest times. The pharmacists often worked alone for the first two, and last two hours of each day. The pharmacy could use 'multi-skillers' if they felt they need additional support. The 'multi-skillers' were people who normally worked in other areas of the supermarket, for example, on the checkouts. But they had completed some training to allow them to carry out basic tasks in the pharmacy, for example, taking in prescriptions and handing out dispensed medicines.

The team members were able to access the online training system, Tesco Academy, to help them keep their knowledge and skills up to date. They received training modules to complete every month. Many of the modules were mandatory to complete. The team members were also able to voluntarily choose a module if they felt the need to learn about a specific healthcare related topic, or needed help carrying out a certain process. The team members did not always receive set time during the day to allow them to complete the modules. And so, they completed some training in their own time. The pharmacy had an annual appraisal process. The appraisals were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve.

The team attended ad-hoc, informal meetings when the pharmacy was quiet. And discussed topics such as company news, targets and patient safety. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members felt comfortable to give feedback or raise concerns with the regular pharmacists or the pharmacy's regional development manager, to help improve the pharmacy's services. The pharmacy had a whistleblowing policy. The team was set various targets to achieve. These included the number of prescription items they dispensed and the number of services they provided. The team members felt the targets did not impact their ability to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean, tidy and professional in appearance. There was signage outside of the supermarket which indicated there was a pharmacy inside the building. The dispensary was small, but the team was managing the space well. It was generally tidy and well organised during the inspection. Floor spaces were kept clear to minimise the risk of trips and falls.

There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation.

There was a good-sized, soundproofed consultation room at the side of the pharmacy retail area. The room was smart and professional in appearance and was signposted by a sign on the door. It was kept locked when it was not in use to prevent the risk of any unauthorised access. It contained two seats and had a sink. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. And the pharmacy manages its services well, so it can deliver them safely. The pharmacy provides medicines to some people in multi-compartmental compliance packs to help them take them correctly. And it manages the risks associated with the service appropriately. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had level access from the supermarket car park to an automatic entrance door. And so, people with prams and wheelchairs could enter the pharmacy area unaided. There were several disabled and parent and child parking spaces. The pharmacy could supply people with large print dispensing labels if needed. The pharmacy advertised its services and opening hours. It had a small healthy living zone close to the seating area near to the pharmacy counter. And there were several healthcare related leaflets available for people to select and take away with them.

The team members regularly used various stickers that they could use as an alert before they handed out medicines to people. For example, to highlight if a person was eligible for a flu vaccination. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. Baskets were available to hold prescriptions and medicines. This helped the team stop people’s prescriptions from getting mixed up. The pharmacy had a policy for every dispensed medicine bag to be opened for a third and final check, before it was handed out to people. The regular pharmacist explained he told people before handed out their medicines, that he was going to do the final check in the dispensary. He said most people appreciated the reasons why he was completing the check and they were normally happy to wait while he did so. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes. And it supplied the packs to people on either a weekly or monthly basis. The team was responsible for ordering people’s prescriptions. And this was done around a week in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the medication on a bench furthest away from the pharmacy counter. This was to minimise distractions. The pharmacy stored each person’s documents, for example, the master sheets and prescriptions in individual baskets and kept them on a designated shelf. This was to prevent them being mixed up with other people’s prescriptions. The team members managed the workload over a four-week cycle to spread the work out evenly. And they completed the dispensing of the packs around a week before the pack was due to be supplied. The team members used the master sheets to check off prescriptions and confirm they were accurate. The sheets detailed each medicine the person was regularly prescribed. And the time they were to take it. The team also kept details of any changes to people's medicines. And it kept records of who had authorised the change, for example, the person's GP. The packs were supplied with information which listed the

medicines in the packs and the directions. And information to help people visually identify them. For example, the colour or shape of the tablet or capsule. The pharmacy routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used alert stickers attached to people's medication bags to remind them that the bag contained a high-risk medicine. The pharmacist gave the person collecting the medicine additional advice if there was a need to do so. The pharmacist was seen reminding a person prescribed warfarin of the importance of having regular blood tests. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No-one had been identified.

Pharmacy (P) medicines were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines in the dispensary tidily. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next twelve months. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had not received any training on how to follow the directive and did not have the correct type of scanners. The team members were unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The pharmacy had three CD cabinets in place. And they were secured and of an appropriate size. The medicines inside were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team members used tweezers and rollers to help dispense multi-compartmental compliance packs. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private.

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.