General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Prince Avenue, WESTCLIFF-ON-SEA, Essex, SS0 0JP

Pharmacy reference: 1092622

Type of pharmacy: Community

Date of inspection: 22/08/2022

Pharmacy context

The pharmacy is in a large superstore in a largely residential area near Southend-on-Sea. It receives most of its prescriptions electronically. And it provides a range of services, including NHS prescription dispensing, the New Medicine Service and the Discharge Medicines Service. It also provides medicines as part of the Community Pharmacist Consultation Service.

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	Standards met	1.2	Good practice	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce future risks.
2. Staff	Standards met	2.2	Good practice	Team members undertake structured ongoing training to help keep their knowledge and skills up to date. And they get time set aside to complete it.
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 routinely records and regularly reviews any mistakes that happen during the dispensing process. It shares this information with other pharmacies in the company and it uses this information to help make its services safer and reduce any future risk. The pharmacy identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information appropriately. And it regularly seeks feedback from people who use the pharmacy. The pharmacy largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) and it managed the risks associated with its services well. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns and reviews were documented. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The outcomes from the reviews were discussed openly during the regular team meetings. And learning points were also shared with other pharmacies in the group. Some drawer edges where certain medicines were kept were highlighted to help minimise the chance of the wrong items being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong type of device had been supplied to a person. The shelf edge where the two medicines involved in the incident was clearly highlighted to help staff select the correct device.

Workspace in the dispensary was limited but there were clear areas for dispensing and checking of dispensed items. And baskets were used to minimise the risk of medicines being transferred to a different prescription. There was an organised workflow which helped staff to prioritise tasks and manage the workload. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The team members' roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would remain closed and a notice would be displayed if the pharmacist had not turned up in the morning. She explained that she would follow the company's guidelines and inform the pharmacy's head office. Team members would remain available at the pharmacy to signpost people to other local pharmacies if needed. And a list of these pharmacies was displayed at the medicines counter. Team members would return prescriptions to the NHS electronic system if needed. The dispenser knew that she should not hand out any dispensed items or sell any medicines if there was no responsible pharmacist (RP). And she knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical

amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly. The private prescription records were mostly completed correctly, but the correct prescriber details and date on the prescription were not always recorded. And this could make it harder for the pharmacy to find these details if there was a future query. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacist said that he would ensure that the private prescription and emergency supply records were completed properly in future.

The pharmacy had its confidential waste removed by a specialist waste contractor and its computers were password protected. People using the pharmacy could not see information on the computer screens. And bagged items waiting collection could not be viewed by people using the pharmacy. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Team members had completed training about the protecting people's personal information.

The pharmacy had carried out yearly patient satisfaction surveys, but because of the pandemic it had not carried one out since 2020. The pharmacy manager regularly attended an area conference call to discuss customer satisfaction and any complaints received. The complaints procedure was available for team members to follow if needed and details about how people could complain were available on the pharmacy's website. People attending the pharmacy were sometimes provided with feedback cards informing them about how to provide feedback about the service they had received. There were three ways people could provide the feedback (online, scan the QR code or by phone). The dispenser said that she was not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy's head office. Team members could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. And the pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy is good at providing ongoing training for its team members. They have structured ongoing training and get protected time set aside at work to complete it. The team discusses adverse incidents and uses these to learn and improve. The pharmacy has enough trained team members to provide its services safely. Team members can take professional decisions to ensure people taking medicines are safe. And these are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one pharmacy technician and one trained dispenser working at the start of the inspection. The pharmacy technician finished her shift soon after the inspector arrived. A locum pharmacist started her shift during the inspection. And there was a hand over period between the pharmacists. Team members had done the right training for their role and they wore smart uniforms with name badges which displayed their job role. Team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed throughout the inspection.

The dispenser was confident when speaking with people. She asked people relevant questions to check whether a medicine was suitable for them buy over the counter. She was aware of the restrictions on sales of pseudoephedrine-containing products. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care.

Team members undertook regular training modules provided by the pharmacy's head office. Each team member had a training record card and training was monitored by the pharmacy manager. Team members were allowed protected training time during the day to complete any training. And this could be done in the consultation room to help minimise distractions. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And he discussed some recent training he had done, including ambulatory blood pressure training and inhaler techniques. The pharmacists felt able to take professional decisions.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacy had regular team meetings and the dispenser said that information was also regularly shared in a group chat. Team members received yearly appraisals and performance reviews and these were documented. The pharmacy received newsletters from the pharmacy's head office, including 'safety starts here' and 'pharmacy healthcare news'. Once read, team members had to sign the 'Team 5' sheet to indicate that they had understood the information. The 'Team 5' sheet was checked by the pharmacy manager to ensure that all team members had read and understood the relevant information. The team also regularly discussed the dispensing mistake reviews. Targets were set for the New Medicine Service. The pharmacist said that the pharmacy usually met the targets, but he would not let the targets affect his professional judgement. And he provided the service for the benefit of people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access and pharmacy-only medicines were kept behind the counter. The pharmacy was bright, clean, and tidy throughout and this presented a professional image. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available and the room temperature was suitable for storing medicines.

There was one chair outside the consultation room for people to use while waiting. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was located in the shop area next to the pharmacy. It was suitably equipped, well-screened and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access into the store and there was level access to the pharmacy at the rear of the store. Services and opening times were clearly advertised and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order. And the pharmacy could produce large-print labels if needed.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept on the person's medication record. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were routinely highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted and the dispensed items for these prescriptions were kept in separate tubs to other dispensed items. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. The pharmacist said that CDs and fridge items were checked with people when handed out. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information leaflets, warning cards available and warning stickers available.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock. The pharmacy kept lists of its short-dated items which helped team members easily identify them, and these items were removed and disposed of appropriately around one month before they were due to expire.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Prescriptions were annotated with any stock issues or whether the patient had been made aware of any issues with obtaining their medicines. The pharmacist said that uncollected prescriptions were checked regularly and people were sent a text message when their medicine was ready for collection. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were

clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

The pharmacy had suitable equipment for measuring liquids and its triangle tablet counters were clean. A separate counter was marked for cytotoxic use only which helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed. Fridge temperatures were checked daily and the maximum and minimum temperatures were routinely recorded. Records indicated that the temperatures were consistently within the recommended range. And the fridge was suitable for storing medicines and was not overstocked.

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.