General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Finsley Gate, BURNLEY, Lancashire, BB11 2HE

Pharmacy reference: 1092975

Type of pharmacy: Community

Date of inspection: 11/06/2019

Pharmacy context

The pharmacy is in a 24-hour Tesco supermarket in the centre of Burnley. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide a range of services, including medicines use reviews (MUR), the NHS New Medicines Service (NMS), seasonal flu vaccinations and meningitis vaccinations for people travelling for the Hajj pilgrimage. And, they provide a substance misuse service, including supervised consumption, and they supply medicines in multi-compartmental compliance packs.

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	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 up-to-date procedures to identify and manage risks to its services. It has an audit of key governance and safety tasks. But, pharmacy team members don't always complete the audit to help identify areas where they may need to make improvements. The pharmacy mostly maintains the records it must by law. And it has systems in place to manage people's complaints. Pharmacy team members read and follow the procedures. They complete regular training, so they know how to keep people's private information secure. They understand how important their role is in keeping people's private information safe. And, they know what to do if there is a concern about a child or vulnerable adult. Pharmacy team members regularly discuss mistakes that happen. They sometimes use this information to learn and make changes to help prevent similar mistakes happening again. But they don't always record or discuss information about why they happen. So, they may miss opportunities to improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place, which were available electronically. The superintendent pharmacist's team had reviewed the sample of procedures seen in 2018. And had scheduled the next review of the procedures for 2020. Pharmacy team members had read and signed the SOPs since the last review in 2018. The pharmacy defined the roles of the pharmacy team members in each procedure.

The pharmacist and the accuracy checking technician highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. The pharmacy team discussed the errors made. And they discussed why a mistake had happened. But, they did not record any information about why a mistake had happened. The pharmacist analysed the data collected about mistakes every three months. They discussed any patterns found with the team and made changes to prevent similar mistakes happening again. One example was attaching alert stickers to shelves in front of pregabalin and gabapentin to help prevent picking errors. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using an electronic reporting system, and a copy of reports were printed and kept. A sample of reports were seen and were detailed. But, they did not record much information about why mistakes had happened to help aid learning.

The pharmacy received a bulletin periodically called "Safety Starts Here". It told the team about any pharmacy or professional issues that had occurred elsewhere in the company. Pharmacy team members signed the bulletin to confirm they had read it. And they attached the latest bulletin to a noticeboard for everyone to see. There was a recent example available. It gave the team information about the risk of mistakes with look-alike and sound alike medicines quinine and quetiapine. The pharmacist demonstrated that the products had been moved in the stock drawers in response to the bulletin.

Pharmacy team members were required to complete a Safe and Legal checklist each day. The checklist varied each day. And it prompted the team to check various aspects of legal and operational compliance. For example, whether the controlled drugs (CD) cabinet was locked and the keys were being stored securely, whether confidential waste was being disposed of correctly and whether near miss errors were being recorded. But, the checklist was not being regularly completed. And, it had not

been completed for some time. The pharmacist said he could not explain why the checklist had not been done. A discussion took place about why the checklist was useful to help highlight and manage risks.

The pharmacy had a procedure to deal with complaints handling and reporting. It had card to hand out to people asking them to fill in an online survey. But it did not advertise in the retail area how people could make a complaint. It collected feedback from people by using questionnaires. One feedback point was having the required stock available. The team had since tried different methods to manage their stock more effectively. They had decided to make sure each item dispensed was automatically re-ordered once dispensed to make sure enough stock was held.

The pharmacy had up to date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity weekly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. They kept private prescription records electronically. But the records did not always accurately record the date on the prescription. And, they recorded emergency supplies of medicines electronically. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy collected confidential waste in separate bags. Pharmacy team members sealed the bags when they were full and sent them to the store cash office for destruction. The pharmacy team had been trained to protect privacy and confidentiality. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR). There was no evidence that the pharmacy had been assessed for GDPR compliance.

When asked about safeguarding, a dispenser some examples of symptoms that would raise their concerns in both children and adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to local safeguarding contacts for advice. The pharmacy had contact details available for the local safeguarding service. Pharmacists and pharmacy technicians completed distance learning via The Centre for Pharmacy Postgraduate Education (CPPE). Other staff said they had trained. But they did not know when or how often they needed to renew their training., They could not access their training records during the inspection.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete regular training. And, they reflect on their own performance, and discuss any training needs with the pharmacist. The pharmacy team members can discuss issues and act on ideas to support the safe delivery of services. But they don't always establish and discuss specific causes of mistakes in dispensing. So, they may miss chances to learn from errors and make changes to improve safety.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were two pharmacists, a dispenser and a trainee medicines counter assistant. Pharmacy team members completed training by reading various trade press materials. And by completing training modules via Tesco's online training system every few months. Pharmacy team members received an appraisal with the pharmacy manager every year. They discussed their performance and set objectives for improvement. One example of an objective was for a dispenser to learn more about the disposal of waste medicines. They said they had learned by watching someone more experienced.

The dispenser explained that she would raise professional concerns with the pharmacist manager, another regular pharmacist or the store manager. She said she felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a whistleblowing policy that the team were aware of.

The pharmacy team communicated with an open working dialogue during the inspection. The dispenser said she was told by the pharmacist when she had made a mistake. The discussion that followed did not fully explore why she had made the mistake. But, she said she would always try and change something to prevent the mistake happening again.

Pharmacy team members explained a change they had made after they had identified areas for improvement. They had introduced a communications book. They used the book to pass messages about patients and their needs between different members of the team working on different shifts. A dispenser said this had helped to make sure that pharmacy team members were fully informed and helped them to help people more effectively.

The pharmacy asked the team to meet targets in areas such as prescription volume, over the counter sales and the number of medicine use review (MUR) and New Medicines Service (NMS) consultations delivered. They felt that targets were generally achievable. But, they did not always feel supported to help achieve their targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises.

The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a WC elsewhere in the store with a sink providing hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. And it generally provides its services safely and effectively. It stores, sources and manages medicines safely. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines. And to identify what they look like. The team takes steps to identify people taking high-risk medicines. And it provides them with some advice to help people take these medicines safely.

Inspector's evidence

The pharmacy was accessible via level access from the store car park through automatic doors. The pharmacy team could provide large-print labels and instruction sheets to people with visual impairment. And there was a hearing induction loop available for people with hearing impairment.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent people's prescriptions being mixed up.

The pharmacy supplied medicines in multi-compartmental compliance packs when requested. Pharmacy team members attached labels to the packs, so people had written instructions of how to take the medicines. And it added descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient information leaflets about their medicines each month. And, they documented any changes to medicines provided in packs on the patient's electronic record. But they did not always record details about who had requested the changes to be made.

Pharmacy team members said they checked medicine expiry dates every 12 weeks. And records were seen. But, the last full check of stock was carried out in January 2019. They highlighted any short-dated items with a pen on the pack up to three months in advance of its expiry. And they checked product expiry dates as part of the dispensing and checking process. There were no out of date medicines found on the shelves. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed.

The pharmacy obtained medicines from four licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the controlled drugs (CD) cabinet tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. They kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. But, they did not always keep records of fridge temperatures, as required by the pharmacy's procedures and Safe and Legal Audit process. The fridge temperature was within acceptable limits during the inspection.

The pharmacy used the computer system to highlight patients at risk when prescribed valproate. The

pharmacy team alerted the pharmacist to relevant patients. The pharmacist said they would ask each at-risk patient questions to make sure they were aware of the risks of the medicine during pregnancy. And whether they had adequate pregnancy prevention in place. The pharmacy had material available to give to people each time they received a supply.

The pharmacy team were aware of the recent changes to the law under the Falsified Medicines Directive (FMD) to help identify counterfeit medicines. But, the pharmacy had not provided any equipment or software for the team to scan products. And, there were no procedures for the process and the team had not been trained. So, it was not complying with current legislation.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet.

The pharmacy team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone. The dispensary fridge was in good working order. And the team used it to store medicines only. Access to all equipment was restricted and all items were stored securely.

The pharmacy kept sensitive information and materials in restricted areas. It positioned computer terminals away from public view. And they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view.

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.