General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Market Street, Hemsworth, PONTEFRACT, West Yorkshire, WF9 4LB

Pharmacy reference: 1095962

Type of pharmacy: Community

Date of inspection: 07/01/2020

Pharmacy context

This community pharmacy is in a Tesco supermarket. The pharmacy dispenses NHS and private prescriptions. And it supplies multi-compartment compliance packs to help people take their medicines. The pharmacy provides the seasonal flu vaccination service. And it provides a supervised methadone consumption service. The pharmacy offers the community pharmacist consultation service (CPCS).

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 team members act competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again.
		1.4	Good practice	People using the pharmacy can raise concerns and provide feedback. The team pro-actively responds when people using the pharmacy services raise concerns.
2. Staff	Good practice	2.2	Good practice	The pharmacy is good at providing team members with opportunities to develop their knowledge. And it gives team members regular feedback on their performance. The pharmacy supports team members who identify areas of practice they wish to develop. So, they can keep their skills and knowledge up-to-date.
		2.5	Good practice	The pharmacy encourages the team members to share ideas on how to improve the efficient delivery of services. And it engages with team members when changes are introduced. So, they understand why the changes are happening and support the implementation of the changes.
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 team identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services. The team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members act competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again. The pharmacy has appropriate arrangements to protect people's private information. And it keeps most of the records it needs to by law.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The pharmacy kept the SOPs in a dedicated folder. The folder was disorganised and contained several documents as well as the SOPs. So, it was difficult to locate specific SOPs. There were several old SOP signature sheets for team members who no longer worked at the pharmacy. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. And the team member involved recorded their own error. A sample of the near miss error records looked at found that the team sometimes recorded details of what had been prescribed and dispensed to spot patterns. The team members recorded what had caused the error and the steps they had taken to prevent the error happening again. These included double checking the medicine picked and double checking the pack size. The pharmacist manager regularly reviewed the near miss errors to spot patterns. Following one review the pharmacist manager had identified errors with prescriptions for fluoxetine 30mg. The pharmacist manager placed stickers on the shelf holding fluoxetine to prompt the team to check the strength selected and separated the two strengths. The pharmacist manager advised the team that the 30mg strength was rarely prescribed. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. All team members were made aware of the dispensing incident and the actions put in place to prevent the same error happening again. After an error with the wrong strength of cream the team placed the two strengths in different drawers. And the team members were reminded to double check the dispensed product at the point of handing over to the person.

The pharmacist manager completed a monthly patient safety report of the near miss errors and dispensing incidents. And shared the results with the team verbally and via the WhatsApp group. A recent report highlighted labelling errors because team members were accepting the default directions that appeared on the computer screen without checking with the prescription. The report stated the team was reminded to check the computer screen and make any amendments before printing the label. This report also stated that team members were asked to mark all sides of a split pack to reduce

the risk of people receiving the incorrect quantity. The pharmacist manager completed an annual patient safety report. This highlighted key learning points amongst the team. These included asking the team to circle the age on a prescription for a child under 12. So, the pharmacist could ensure the dose prescribed was correct. The latest report stated that one of the objectives for the next 12 months was for the team to maintain the continuous learning environment.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And in the consultation room which limited how many people could see them whilst on the premises. The latest survey included positive comments about the service provided by the team and the pharmacists. The survey highlighted comments from people about having somewhere for a private conversation with the team. The survey results indicated that all team members were to offer people the use of the consultation room for private conversations. The pharmacy had provided a needle exchange service but changes to the team had led to the suspension of the service. People regularly asked the team if the service was available as alternate providers of the service were some distance away. In response to these frequent requests the pharmacist manager was re-introducing the service.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies met legal requirements. A sample of records of emergency supplies of medicines found one entry did not include a reason for the supply. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed a notice informing people to visit the Tesco website to see the GDPR privacy notice. The team separated confidential waste for shredding offsite. The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacists had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And the team had completed Dementia Friends training. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has a team with the qualifications to support the pharmacy's services and team members support each other in their day-to-day work. The pharmacy is good at providing the team members with opportunities to develop their knowledge and skills. And it gives team members regular feedback on their performance. The pharmacy encourages the team members to share ideas on how to improve the efficient delivery of services. And it engages with team members when changes are introduced. So, they understand why the changes are happening and support the implementation of the changes.

Inspector's evidence

The pharmacist manager and regular pharmacists covered the opening hours. The pharmacy team consisted of a full-time pharmacy technician and four part-time qualified dispensers. At the time of the inspection the pharmacist manager and one of the dispensers were on duty. The pharmacy provided extra training through e-learning modules. The team members had protected time to complete the training. The pharmacy provided performance reviews for the team members. So, they had a chance to receive feedback and discuss development needs. One of the qualified dispensers had asked about training to level 3 national vocational qualification (NVQ) to become a pharmacy technician. This member of the team had been in post 18 months after moving from the customer service desk in the store. The dispenser enjoyed working in the pharmacy and wanted the challenge offered by this qualification.

The pharmacist manager used a WhatsApp group to ensure all team members were kept up-to-date with information. Such as changes made following the monthly patient safety report or dispensing errors. And when new training modules were released. The pharmacist manager also used the WhatsApp group to ask team members to cover last minute absence. The pharmacist manager involved all the team with patient safety reports and asked team members for their suggestions to reduce errors. The team had identified products with similar sounding names and discussed the risk of errors associated with these medicines. Following this discussion, the team separated amitriptyline and amlodipine. The team put this in place before a similar intuitive was released by the company. The pharmacist manager spent time with the team discussing changes to processes, so all team members were aware of the changes and why they were happening. This helped the team understand the change and engage with the process of implementing the change. For example, the company recently introduced a system that replaced baskets for holding prescriptions awaiting medicine stock to clips holding each prescription and the labels generated. The pharmacist manager explained the process and the improvements to safety with this system. So, the team members knew why it was happening and they supported the change.

The pharmacy had targets for services such as Medicine Use Reviews (MURs). And the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink, alcohol gel for hand cleansing and disposable gloves. The dispensary was small with limited work space. The team managed this by keeping the dispensary work benches free of clutter. The team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. And the pharmacists invited people in to the consultation room to take their methadone doses. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. And it manages its services well. The pharmacy gets is medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via the store entrance through an automatic door. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role. The pharmacy provided the flu vaccination service against up-to-date patient group directions (PGDs). These provided the pharmacists with the legal authority to administer the flu vaccine. People liked the convenience of the service which the pharmacy offered six days a week from 8am to 8pm.

The pharmacy provided multi-compartment compliance packs to help around 17 people take their medicines. People received monthly or weekly supplies depending on their needs. The team had a list of people who received the packs. And used the list to record when the last supply was made. The team ordered the prescriptions for one person. All the other people ordered their own prescriptions. The team asked people to order their prescriptions a few days before their next supply of packs. This allowed the team time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and queried any changes with the GP team. The team used baskets labelled with the person’s name and address to hold stock for the packs. The team members recorded the descriptions of the products within the packs. But they did not supply the manufacturer’s patient information leaflets. The hospital pharmacy team contacted the pharmacy when people were admitted to check the medicines prescribed. And the pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. The pharmacy team had a separate record to capture changes to the medicines in the packs. The record included who had accurately checked the prescription, the date of the change and details of the change.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses using the MethaMeasure pump. The pump was linked to a laptop that the pharmacist updated with the methadone doses on receipt of a new prescription. When the person presented at the pharmacy the pharmacist selected their records from the laptop. And sent the dose to the pump to pour in to a cup for the person to take. The pharmacists attached notes to the prescriptions, so all pharmacists were aware of any issues. For example, one prescription had a note asking the person to contact their key worker. The pharmacist passed this information on to the person before handing their dose over. The pharmacy kept the prescriptions in a dedicated box folder in alphabetical order, so they were easy to locate.

The team members provided a service to people who needed their medicines supplied each week. The team used baskets labelled with the person’s name and address to hold stock. So, the team was able to supply the medicines without delay. The pharmacy provided some separation of labelling, dispensing

and checking of prescriptions. Usually one team member labelled the prescriptions and another team member picked the stock. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves and they used this as a prompt to check what they had picked. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had completed regular audits of the supply of valproate to check if anyone met the criteria. Only one person met the criteria and they were given appropriate advice. The pharmacy had the PPP pack to provide people with information when required. The team sometimes asked people on other high-risk medicines for information such as latest test results and doses. But the team did not always record this information on to the electronic patient record (PMR).

The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was in January 2020. The team highlighted medicines with a short expiry date. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of morphine oral solution with 90 days use once opened had a date of opening of 30 October 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). The pharmacist manager had been given a date for the installation of FMD equipment in 2019 but this had not happened. The pharmacy had not been given a new date for the installation of the FMD equipment. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via internal messages and the pharmacist manager received them to their own email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And the team mostly uses the pharmacy's facilities and equipment in a way to protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. The pharmacists checked the MethaMeasure methadone pump for accuracy each morning. And the pharmacist manager had spoken to the MethaMeasure company for advice on when to update the pump. The pharmacy had a large fridge to store medicines kept at these temperatures.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. And it kept the computer screen in the consultation room locked when it was not in use. The pharmacy stored completed prescriptions away from public view. And it mostly held private information in the dispensary and rear areas, which had restricted access. But old CD registers containing people's private information were found in unlocked cupboards in the consultation room. The team used cordless telephones to make sure telephone conversations were held 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.