General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instores Pharmacy, Reigate Road, Hookwood, HORLEY, Surrey, RH6 0AT

Pharmacy reference: 1101425

Type of pharmacy: Community

Date of inspection: 09/07/2019

Pharmacy context

This is a community pharmacy set within a supermarket near Gatwick airport. It opens extended hours seven days a week. Most people who use the pharmacy also use the supermarket. The pharmacy sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers winter influenza (flu) vaccinations and a private health check 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	2.2	Good practice	Members of the pharmacy team receive set aside time to train and to keep their skills and knowledge up to date. And they learn from their own and other people's mistakes.
		2.4	Good practice	Staff work effectively together as a team and have a work culture of openness, honesty and learning.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy makes sure that its services are accessible and meet the needs of the community it serves. It promotes the benefits of its services too.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy adequately monitors the safety of its services. It has appropriate insurance to protect people if things do go wrong. And it generally keeps all the records it needs to by law. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They work to professional standards and identify and manage risks appropriately. And they usually keep people's private information safe. The pharmacy team generally logs, reviews and learns from the mistakes it makes. And it understands its role in protecting vulnerable people.

Inspector's evidence

The pharmacy had business continuity arrangements in place to deal with disruptions to its services. It also had standard operating procedures (SOPs) for the services it provided. And these have been reviewed since the last inspection. The pharmacy's team members were required to read, sign and follow the SOPs relevant to their roles.

The team members responsible for the dispensing process tried to keep the dispensing workstations tidy. They used plastic baskets to separate people's prescriptions and to help them prioritize the dispensing workload. Systems were in place to record and review dispensing errors and near misses. But near misses haven't always been recorded. The pharmacy team discussed its mistakes to share learning and reviewed them periodically to help it strengthen its dispensing process. It has highlighted and separated some stocks of medicines, such as different strengths of prednisolone, escitalopram and enalapril, to reduce the risk of staff picking the wrong product.

The pharmacy displayed a notice that identified the responsible pharmacist (RP) on duty. And its team members were required to wear name badges which identified their roles within the pharmacy. They knew what they could and couldn't do, what they were responsible for and when they might seek help; for example, they referred repeated requests for the same or similar products to a pharmacist.

A complaints procedure was in place and patient satisfaction surveys were undertaken annually. People could provide feedback about the pharmacy in-store, online or by contacting the company's customer service department. The pharmacy and its team have received positive feedback from people who have used it services. The results of last year's patient satisfaction survey were published online. Staff tried to keep people's preferred makes of medicines in stock when they were asked to do so.

The pharmacy had insurance arrangements in place, including professional indemnity, through the National Pharmacy Association (NPA). The pharmacy's controlled drug (CD) register, its records for emergency supplies and its RP records were adequately maintained. The CD register's running balance was checked regularly. The prescriber's details weren't always correctly recorded in the pharmacy's private prescription records. The date a 'specials' line was obtained and when it was supplied weren't always recorded in the pharmacy's 'specials' records.

An information governance policy was in place which staff were required to read and sign. A notice was displayed next to the pharmacy's counter to tell people how their personal data was used and kept. Arrangements were in place for confidential waste to be collected and sent to a centralized point for secure destruction. The pharmacy stored its prescriptions in such a way to prevent people's names and

addresses being visible to the public.

The pharmacy's team members were required to complete safeguarding training relevant to their roles. Contact details for the relevant safeguarding authorities were available. Staff could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide safe and effective care. But it could do more to make sure it has the right people working at the right time. The pharmacy's team members make appropriate decisions about what is right for the people they care for. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets. The pharmacy encourages its team members to give feedback. And its staff work effectively together as a team and have a work culture of openness, honesty and learning. They receive set aside time to train and to keep their skills and knowledge up to date. And they learn from their own and other people's mistakes.

Inspector's evidence

The pharmacy opened for 100 hours a week. And it dispensed about 3,500 prescription items a month. The pharmacy team consisted of a full-time pharmacist manager (the RP), a full-time pharmacist, a part-time pharmacist, three full-time dispensing assistants, a part-time dispensing assistant and two full-time trainee dispensing assistants.

The RP, one dispensing assistant and two trainee dispensing assistants were working in the pharmacy at the time of the inspection. A second pharmacist arrived part way through the inspection. The pharmacy relied upon its staff and locum pharmacists to cover any absences. All staff who worked in the pharmacy have completed or were undertaking accredited training relevant to their roles.

Staff supported each other so prescriptions were processed in a timely manner and people were served promptly. The pharmacists supervised and oversaw the supply of medicines and advice given by staff. But they sometimes needed to self-check the prescriptions they assembled and deal with people at the pharmacy counter during their shifts. A sales of medicines protocol was in place which the pharmacy team needed to follow. A member of the pharmacy team described the questions she would ask when making over-the-counter recommendations and when she would refer people to a pharmacist; for example, requests for treatments for pets, people who were pregnant or people with long-term health conditions.

The pharmacy's team members discussed their performance and development needs with their line manager. They were encouraged to keep their knowledge up to date by completing accredited training and online training. They received set aside time to train and to read the company's newsletter on professional matters while at work. Staff were also encouraged to learn from their mistakes and share any learning outcomes with their colleagues.

One-to-one discussions, team huddles and a 'WhatsApp' group were used to update the pharmacy's team members and to share learning from mistakes or people's feedback. Staff felt comfortable in providing suggestions about the pharmacy during team meetings. And they knew how to raise a concern if they had one. The pharmacy's repeat prescription process was strengthened following staff feedback.

The pharmacy's team members didn't feel their professional judgement or patient safety were affected by company targets. Medicines Use Reviews (MURs) and New Medicine Service (NMS) consultations

were only provided by suitably qualified pharmacists when it was clinically appropriate to do so and when the workload allowed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The pharmacy was bright, clean, professionally presented and air-conditioned. It was situated near the health and beauty area of the supermarket.

The pharmacy had the workbench and storage space it needed for its current workload. But some areas of its dispensary were cluttered and needed reorganizing. And some prescription bags which couldn’t be accommodated in the prescription retrieval bay were stored on the floor.

A consultation room was available if people needed to speak to a team member in private. And it was locked when not in use to ensure its contents were kept secure.

The pharmacy was cleaned by a cleaning contractor. But the cleaner wasn’t left unsupervised in the pharmacy. The pharmacy team was also responsible for keeping the registered pharmacy area clean and tidy. The pharmacy had a supply of hot and cold water. It also had some antibacterial hand wash and alcoholic hand sanitiser gel.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes sure that its services are accessible and meet the needs of the community it serves. It promotes the benefits of its services too. The pharmacy's working practices are safe and effective. Members of the pharmacy team are helpful. And they generally make sure people have the information they need so that they can use their medicines safely. The pharmacy team checks stocks of medicines regularly to make sure they are in-date and fit for purpose. The pharmacy gets its medicines from reputable sources and usually stores them appropriately. And it generally disposes of people's waste medicines safely too.

Inspector's evidence

The supermarket had a large car park for people to use. It had automated doors and its entrance was level with the outside pavement. The pharmacy was open most days of the year and it opened early and stayed open later than usual six days a week. The pharmacy's services were advertised in-store. Staff knew where to signpost people to if a service was not provided. And a signposting folder was available too.

The winter flu vaccination service was established and was well received locally. The pharmacy team promoted its benefits to at-risk groups, carers, staff of neighbouring businesses and customers attending the pharmacy. Some people chose to be vaccinated at the pharmacy rather than their doctor's surgery for convenience or because they were not eligible for the NHS service. The pharmacy has the appropriate anaphylaxis resources it needs for its vaccination service.

The pharmacy offered private health checks. The pharmacy team took the time to provide people with health and wellbeing advice. And people identified of being at significant risk of diabetes or heart disease were signposted to their clinician. The pharmacy provided about twelve MURs and two NMS consultations a week. People provided their written consent when recruited for these. The pharmacy team targeted at-risk groups in line with national guidelines. And there have been positive outcomes for people using these services; for example, people with a persistent cough or swollen ankles taking blood pressure medication were routinely referred to their clinician.

The pharmacy offered private patient group directions for malaria prevention and the treatment of erectile dysfunction. But the demand for these were minimal as over-the-counter products were now available.

Staff followed the pharmacy's SOPs. They referred to prescriptions when labelling and picking products. And they initialled each dispensing label. Assembled prescriptions were checked by a pharmacist who was also seen initialling the dispensing label. And prescriptions were not handed out to people until an additional accuracy check was done at the point of supply.

The pharmacy used disposable and tamper-evident multi-compartment compliance packs for that dispensing service. A dispensing audit trail was maintained for the compliance aids seen. A brief description of each medicine contained within the compliance aids was provided. But patient information leaflets (PILs) haven't always been supplied, as required by the SOPs, with some people's weekly compliance aids. Prescriptions were highlighted to alert staff when a pharmacist needed to

counsel people and when CDs or refrigerated items needed to be added. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Valproate educational materials were available at the pharmacy.

The pharmacy used recognised wholesalers, such as AAH, Alliance Healthcare, Oakwood Distribution Ltd. and Phoenix, to obtain its medicines and medical devices. It stored its stock, which needed to be refrigerated, appropriately between 2 and 8 degrees Celsius. It kept most of its medicines and medical devices in an organised fashion within their original manufacturer's packaging. But a few split packs were found to contain stock from different batches and manufacturers. Pharmaceutical stock was subject to date checks, which were documented, and stock nearing its expiry date was appropriately marked.

Staff were aware of the Falsified Medicines Directive (FMD). They could check the anti-tampering device on each medicine was intact during the dispensing process. But they couldn't verify and decommission stock at the time of the inspection as the pharmacy didn't have the appropriate equipment nor software to do so. The pharmacy's SOPs hadn't been revised to reflect the changes FMD would bring to the pharmacy's processes. The pharmacy team didn't know when the pharmacy would comply with the requirements of FMD.

Procedures were in place for the handling of patient-returned medicines and medical devices. Patient-returned waste was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. Suitable pharmaceutical waste receptacles were available and in use. But some cytostatic medication was found in a receptacle intended for non-hazardous waste.

A process was in place for dealing with recalls and concerns about medicines or medical devices. Drug and device alerts were retained and annotated with the actions taken following their receipt.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and the facilities it needs to provide its services safely. But it could do more to make sure its equipment is properly maintained.

Inspector's evidence

The pharmacy had up-to-date reference sources available and it had access to the NPA's information department. The pharmacy had a range of clean glass measures. And it had equipment for counting loose tablets and capsules too. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its maximum and minimum temperatures were checked and recorded regularly.

The equipment the pharmacy team used for health checks, such as a blood pressure (BP) monitor and a combined blood glucose and cholesterol monitor, needed to be replaced or checked regularly. The BP monitor was replaced recently. The accuracy of the blood glucose and cholesterol monitor, according to the pharmacy's records, wasn't checked as frequently as required by the company's guidance to its pharmacy teams. But staff had checked its accuracy before the last health check appointment.

The pharmacy had a cordless telephone system to allow its staff to have confidential conversations with people when necessary. Access to the pharmacy computer and the patient medication record system was restricted to authorised personnel and password protected. The computer screen was out of view of the public. But there was only one computer terminal available in the pharmacy. And staff couldn't always access it when they needed to as it was being used by a colleague. So, they sometimes needed to use their own electronic devices to make enquiries or complete their training.

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.