

# Registered pharmacy inspection report

**Pharmacy Name:** Tesco Instore Pharmacy, Askham Bar, Tadcaster Road, Dringhouses, YORK, North Yorkshire, YO24 1LW

**Pharmacy reference:** 1102853

**Type of pharmacy:** Community

**Date of inspection:** 15/01/2020

## Pharmacy context

This is a hundred-hour pharmacy inside a Tesco supermarket in York. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the medicine use reviews, the New Medicines Service (NMS) and flu vaccinations. And it supplies medicines in multi-compartment compliance packs to some people living in their own homes.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	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. But sometimes near misses are not recorded. So, opportunities may be missed to identify causes, and to make changes to prevent it happening again. It has a set of written procedures for the team members to follow to help them deliver the services safely and effectively. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. 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 well signposted and easy to find when entering the supermarket through the main doors. There was a counter to the front where members of the pharmacy team took in and handed out prescriptions. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The dispensary was open plan and allowed the pharmacy team members to see people approaching the pharmacy counter. The responsible pharmacist used a bench closest to the pharmacy counter to complete final checks on prescriptions. And this allowed her to easily oversee any sales of medicines and listen to any advice the team members were giving to people.

The pharmacy had a set of standard operating instructions (SOPs) in place. The pharmacy's superintendent pharmacist's team reviewed the SOPs every two years. And were due to be reviewed July 2020. The team members had read each SOP that was relevant to their role. Each member of the pharmacy team had a separate training log showing which SOPs they had read. The SOPs were also available on PDF format on the desktop, which were convenient and easily accessed. Roles and responsibilities of staff were described in the SOPs.

The pharmacist highlighted near miss errors made by the team when dispensing. And the details of each near miss error were usually recorded on the near miss log. The records demonstrated that none had been recorded since October. And neither had the monthly review. The newly appointed store pharmacist said that she was unsure why this was because she had just started. But she said that although near misses were not being recorded. They did discuss dispensing incidents as they occur. The responsible pharmacist had done recent look a-like sound a-like sound alike (LASA) training with the pharmacy team members. And there were warnings on the various medicines on the shelves. Dispensing errors were recorded electronically and there were paper copies in a file in the pharmacy. There had been an error when "\*\*\*\*". The previous manager had not recorded this. The area manager had contacted the inspector to explain that a retrospective incident report form had been completed. And changes had been made following the error.

The pharmacy displayed the correct responsible pharmacist notice. So, people in the retail area could see the identity the registration number of the responsible pharmacist on duty. The team members explained their roles and responsibilities. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist.

The pharmacy had a formal complaints procedure in place. And it was available for people to see via the pharmacy's practice leaflet which was available in the retail area for self-selection. The pharmacy collected feedback from people by using questionnaires. The responsible pharmacist said that the bags that were in stock were too small for the larger prescriptions. So, she had spoken with the store manager and it was agreed that carrier bags would be ordered so that larger prescriptions could be packed all together in one bag. And this would reduce the risk of only handing out part of the prescription.

The pharmacy had up-to-date professional indemnity insurance. 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. And there were no ongoing balance discrepancies. A physical balance check of a randomly selected CD 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. The pharmacy had an information governance policy which the team members could refer to. The team had completed information governance training in April 2019. And signatures were seen in the file to show that team members had completed the training. Records containing personal identifiable information were held in areas of the pharmacy that only the team members could access. Confidential waste was separated to avoid a mix up with general waste. The confidential waste was periodically collected for destruction off site. The RP had completed training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The team had contact details of the local support teams in the pharmacy. But they were unable to locate these during the inspection.

## 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 good service. They can make suggestions to improve the pharmacy's services. And they know how to raise professional concerns if necessary. The pharmacy provides access to ongoing training to help its team members keep their knowledge and skills refreshed and up to date.

### Inspector's evidence

There was a newly appointed pharmacist who was acting as deputy pharmacy manager until the newly appointed pharmacy manager takes up their post. The RP was supported by two dispensers and one trainee during the inspection. The RP said that sometimes locum pharmacists were not turning up. But she thought that now there were two company employed pharmacists the situation would improve. The pharmacy's staffing rotas were organised in advance to try to ensure enough support was available during the its busiest periods. The team were struggling with the workload on the day of the inspection. A member of the pharmacy team had mentioned this previously to the area manager. He said that he would look into it. But he had not got back to them yet. The RP said that she was new to Tesco systems and was learning on the job. An she had lists of things she wanted to do and change. But finding the time to do these was proving difficult. Team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. The team members could work some additional hours to cover absences and holidays. The RP said that the team had been supportive since she came into post. And they worked hard to provide a good service to people.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various modules. The modules covered various topics, including mandatory compliance training, health and safety, and information governance. Pharmacy team members said that they had their own log in. And they logged in on the computer in the upstairs training room. Team members recalled that they had also received training was on meningitis and flu vaccinations.

The pharmacy had an appraisal process in place for its team members. The appraisals took place every year in March. The appraisals were an opportunity for the team member to discuss which aspects of their roles they enjoyed and where they wanted to improve. They could also take the opportunity to give feedback to improve the services the pharmacy offered. The team members felt comfortable to raise professional concerns with the regular pharmacist or the store manager. The pharmacy had a whistleblowing policy. And so, the team members could raise concerns anonymously. The team was set various targets to achieve. And sometimes they did feel under some pressure to meet these. But the targets did not impact on the ability of the team 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 premises were suitable for the services provided. They were clean and professional in appearance. 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. The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member. There was a desk, chairs and a sink. And it was kept locked when it wasn't in use. The room was smart and professional in appearance and was signposted by a sign on the door. The team said that the pharmacy was sometimes cold, especially in winter. Lighting was bright throughout the premises.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's services are easily accessible to people. It engages with people using the pharmacy to help them improve their health. The pharmacy manages its services appropriately and delivers them safely. And it suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately. The pharmacy team members identify people taking high-risk medicines and give them appropriate support and advice. But they don't always record it. So, they may not be able to refer to this information in the future if they need to.

### Inspector's evidence

The pharmacy had level access from the store car park through automatic doors. So, people with wheelchairs and prams could easily access the premises. There were disabled car park spaces in the car park. The pharmacy was signposted, so it could be easily found from inside the supermarket. The pharmacy advertised its services and opening hours in the retail area. It stocked a range of healthcare related leaflets in the retail area, which people could select and take away with them.

The team members regularly used various stickers during dispensing, and they used these as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used coloured baskets to hold prescriptions and medicines. This helped the team members to prioritise the waiters and to stop people's prescriptions from getting mixed up. They used 'CD' stickers to keep with prescriptions. This system helped the team members check the date of issue of the prescription and helped prevent them from handing out any CDs to people after their prescription had expired. 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 pharmacy supplied medicines in multi-compartment compliance packs to a handful of people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis.

The pharmacy dispensed high-risk medicines for people such as warfarin, lithium and methotrexate. The pharmacist explained that she spoke to people on high-risk medicines opportunistically. But notes were not usually made on the patients record. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. There was a reminder on the shelf where the valproate was stored to remind the team to discuss with the patient.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines in the dispensary tidily. The pharmacy had a process to check the expiry dates of its medicines to make sure none had expired. And records were seen which showed that the process was completed regularly. No out of date medicines were found following a random check of approximately a dozen medicines. The team members used alert stickers

to highlight medicines that were expiring in 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). Team members were unsure of when they were to start following the directive. Drug alerts were received electronically via NPC portal. The alerts were printed, actioned 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 CD cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets 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 gloves to help dispense multi-compartment compliance packs. The fridge used to store medicines was of an appropriate size. 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.