General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Middle Street, Beeston, NOTTINGHAM, Nottinghamshire, NG9 2AR

Pharmacy reference: 1105417

Type of pharmacy: Community

Date of inspection: 17/12/2019

Pharmacy context

This is a community pharmacy set within a supermarket. It is in the centre of a town, on the outskirts of Nottingham. The pharmacy opens extended hours over seven days each week. It sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. The pharmacy supplies some medicines in multi-compartment compliance packs designed to help people to remember to take their medicines. And it offers some private health services including a travel health 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	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 identifies and manages the risks associated with its services. It keeps people's private information secure. It advertises and responds to feedback about its services appropriately. The pharmacy keeps people's private information secure. And it generally keeps the records it must by law. Pharmacy team members understand how to recognise, and report concerns to protect the wellbeing of vulnerable people. They act openly and honestly by sharing information when they make mistakes during dispensing. And they act to reduce risk following these mistakes. But they do not always record their mistakes or the outcomes of these discussions. This may mean they miss opportunities to share learning and measure the success of the actions they take to help reduce risk.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). These included responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The superintendent pharmacist's team reviewed these at least two yearly. And the next planned date for review was July 2020. The SOPs set out the roles and responsibilities of pharmacy team members. And training records associated with SOPs were available for all but one member of the team. The missing record belonged to a dispenser who was on duty. Both herself and the RP, who was the pharmacy manager, confirmed she had read an signed the SOPs as required. The dispenser demonstrated a clear understanding of her job role. For example, she discussed what tasks could not be completed if the RP took absence from the pharmacy. And how to manage a request for an over-the-counter medicine which may not be suitable for a person. Pharmacy team members were observed working in accordance with dispensary SOPs. For example, they completed a 'third check' of assembled medicines against the original prescription prior to handing them out.

Pharmacy team members used workspace in the dispensary well. There were designated areas for labelling, assembling and accuracy checking medicines. The pharmacy had a business continuity plan in place. At the time of inspection, the pharmacy's printer was broken. Pharmacy team members explained the endorsing printer had been fixed the previous day and this was thought to have caused an issue with the main printer. The issue had been reported. And the pharmacy had managed to download Electronic Prescription Service (EPS) tokens and print them through the assistance of another of the company's local pharmacies.

Pharmacists completed daily 'safe and legal' checks. This process formed an audit of daily and weekly checks designed to support the team in maintaining a safe and secure working environment. Details checked included record keeping, patient safety and equipment used to support the delivery of the pharmacy's services. But there were some minor gaps in these records. And there was one recent occasion where the RP had completed two checks on a later date due identifying a missed day. The RP confirmed that all members of the pharmacy team could complete the daily checks.

Pharmacy team members took ownership of their mistakes by discussing them with the pharmacist at the time they occurred. But they did not always complete an entry in the near-miss error record to help inform shared learning from the mistake. The team had recognised and discussed the need to ensure this record was completed. And team members explained that recording had improved recently. A

discussion took place about the benefits of recording all near misses. This would help the team to identify patterns and inform risk reduction actions. There was no regular formal review of near-miss errors taking place. But pharmacy team members could demonstrate recent actions they took to reduce risk following informal discussions. For example, they had applied high-risk warnings to shelf edges for 'look-alike and sound-alike' (LASA) medicines such as sildenafil, sumatriptan and sertraline. And a dispenser explained how she had reflected on a recent near miss where she had selected the wrong brand of metformin.

A 'Safety Starts Here' poster highlighted the number of days the pharmacy had been free from incident. The pharmacy had a dispensing incident reporting procedure in place. And the pharmacy team demonstrated an open and honest approach to incident reporting. Incident reports were submitted to the superintendent pharmacist's office. And monitoring processes were in place to support the pharmacy in applying risk reduction actions to help reduce the risk of similar mistakes occurring. Completed incident reports clearly documented learning and risk reduction actions applied following an incident. For example, pharmacists had been required to sign the bag label for a period of time to prompt additional checks between the personal details on the prescription and assembled medicine following an incident. And pharmacy team members had been required to record the address check upon hand-out during this period of time also. The RP explained how short-term changes to processes such as these prompted vigilance and re-enforced the importance of following the pharmacy's SOPs.

The pharmacy had a complaints procedure. And it provided details of how people could leave feedback or raise a concern about the pharmacy through its practice leaflet. People shopping at the supermarket were able to complete online feedback about their experience through following a link on their till receipt. And this feedback questionnaire specifically asked the person if they had visited the pharmacy. The RP explained how this feedback was shared with the team each quarter. And it was largely positive. The pharmacy also promoted feedback through their annual 'Community Pharmacy Patient Questionnaire'. And it published the results of this questionnaire for people using the pharmacy to see. The RP explained how feedback about how a person had been informed of an out-of-stock medicine had been used to inform learning in the pharmacy.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice contained the correct details of the RP on duty. Entries in the RP record complied with legal requirements. The pharmacy kept records for private prescriptions and emergency supplies within an electronic Prescription Only Medicine (POM) register. Entries within the register generally met legal requirements. But the pharmacy did not always record an accurate date of prescribing or record the correct details of the prescriber when completing the record. The pharmacy retained completed certificates of conformity for unlicensed medicines with full audit trails completed to show who unlicensed medicines had been supplied to. The sample of the CD register examined generally complied with legal requirements. But there was some missing page headers. And some minor omissions by not recording the address of the wholesaler in the register when entering receipt of a CD. The pharmacy maintained running balances in the register. And it checked these balances against physical stock weekly. A physical balance check of MST Continus 60mg tablets complied with the balance recorded in the register. The pharmacy maintained a CD destruction register for patient returned medicines. And the team entered returns in the register on the date of receipt.

The pharmacy displayed a notice explaining to people how it managed their personal data. All pharmacy team members completed mandatory information governance training. And the pharmacy had procedures to support staff in managing confidential information within an information governance folder. The folder provided other guidance to team members. For example, a policy on staff use of social media. The pharmacy held all person identifiable information in staff only areas of the premises.

And pharmacy team members were vigilant in requesting identification from anybody requiring access into the pharmacy. The pharmacy had submitted its annual NHS Data Security and Protection toolkit as required. It disposed of confidential waste in coloured bags. Bags were tied and transferred to a locked receptacle prior to being securely disposed of.

The pharmacy had procedures and information relating to safeguarding vulnerable people. Contact details for safeguarding teams were displayed in the dispensary. All pharmacy team members had completed e-learning on the subject. And they completed mandatory refresher training also. Pharmacy team members could explain how they would recognise and report a safeguarding concern. Pharmacists had regular discussions with the local substance misuse team. And the RP explained this encouraged both parties to share any concerns about a potentially vulnerable person to help monitor and support them. And the RP provided an example of how a concern relating to a person potentially requiring additional support had been referred to the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and knowledgeable people working to provide its services safely and effectively. Pharmacy team members complete regular learning relevant to their role. And they receive support and time at work to complete this learning. They feel confident raising any professional concerns they may have. And they engage in discussions relating to patient safety and risk management.

Inspector's evidence

On duty during the inspection was the RP and a dispenser. Another dispenser joined the team towards the end of the inspection. The pharmacy also employed another full-time pharmacist who acted as duty manager, and a Saturday pharmacist who also acted as duty manager. Locum pharmacists covered days off and annual leave. In total the pharmacy employed four part-time qualified dispensers. And the RP confirmed this provided some flexibility to help cover leave amongst the team. There was some overlap of pharmacists shifts which allowed time for feedback and breaks.

All pharmacy team members engaged in continual learning to support them in their role. And the pharmacy kept training records associated with this learning. Pharmacy team members confirmed they were given time during working hours to support them in completing the learning. And they were also supported by a structured appraisal process. Both dispensers on duty confirmed they were confident in providing feedback through their appraisal.

Pharmacy team members were observed completing tasks with efficiency and were able to focus on completing acute prescriptions in a timely manner. They took turns in serving on the medicine counter. And were observed to be attentive to people’s needs. The RP explained how on some occasion’s pharmacists had to apply self-checks of their work. He explained how a mental break was required between assembling and checking the medicine. And people were informed of an increased waiting time if this situation arose.

The pharmacy did have some targets in place. These related to services, sales and prescriptions. A team member was not aware of what the target was for the flu vaccination service. But she was aware the pharmacy had exceeded it. The RP expressed he was confident in applying his professional judgement when working towards meeting targets. And pharmacy team members supported pharmacists by identifying people during the dispensing process, who could benefit from the services provided.

The pharmacy did not have full staff meetings due to shift patterns. Pharmacy team members explained how information relating to workload management and safety was shared at the beginning of shifts through handovers. But these were not formally documented. Pharmacy team members were asked to sign news bulletins and patient safety reviews after they had read them. The pharmacy had a whistleblowing policy in place. And pharmacy team members were aware of how to provide feedback and escalate a concern if required. A member of the team explained how she had felt confident in providing feedback to a locum pharmacist when she had felt she was not able to safely complete a task being asked of her. This feedback had been taken on-board and the pharmacist had appropriately passed the work to another pharmacist. The same dispenser explained that she felt fully supported in

her role and spoke positively about her colleagues.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitably maintained. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. It consisted of the medicine counter, dispensary, stock room and consultation room. The consultation room was sign-posted and was used by pharmacy team members with people throughout the inspection. The room was a good size and it was professional in appearance.

The dispensary was a sufficient size for the level of activity carried out. Work benches were kept free of non-work-related items. And pharmacy team members explained how they used space on a work bench during quieter times to assemble multi-compartment compliance packs. This helped to manage the risks associated with this activity. The pharmacy's store room provided additional space for holding dispensary sundries, some spare retail stock, appliance and medical waste.

Pharmacy team members reported maintenance issues to a designated help-desk. An issue with the dispensary shelves had been reported. And a maintenance team had attended the pharmacy and had identified some shelves requiring replacement. The manager explained no date had yet been arranged to fit the new shelves. But he had details of the work required in case he needed to make any queries. The pharmacy was clean. It had air conditioning. Lighting throughout the premises was bright. Antibacterial soap was readily available at the pharmacy's sinks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are fully accessible to people. Pharmacy team members ensure that people using the pharmacy receive relevant information about the medicines they are taking. And people who have their medicines dispensed in multi-compartment compliance packs are well supported by the pharmacy team. The pharmacy has processes which help identify and manage the risks associated with providing its services. It obtains its medicines from reputable sources. And it stores and manages its medicines safely.

Inspector's evidence

The pharmacy was clearly signposted from the main road. Further signs inside the supermarket meant that it was easy to find within the store. There was step-free access into the store. The pharmacy advertised details of its opening times and services clearly. Leaflets providing further details of its services were readily available for people to take. Pharmacy team members were aware of signposting requirements. And a dispenser was observed signposting a person to another local pharmacy when the pharmacy did not have an urgently required medicine in stock.

Prescription forms and some assembled bags were annotated with stickers to help identify eligible people for some of the pharmacy's services. The pharmacy manager reflected on positive outcomes from the services provided and through discussions with people. These included helping people to adjust the timing of their medication to achieve better results from taking it and support offered to the families of people requiring palliative care. He described a positive intervention made through the blood pressure service which resulted in a person receiving onward care and monitoring for their condition.

The pharmacy had up-to-date patient group directions (PGDs) and procedures readily available to support the supply of medicines through its private services and the NHS flu vaccination service. The only PGDs in regular use were those for the flu and meningitis vaccinations. The RP explained this was due to the launch of over the counter malaria prophylaxis and Viagra Connect. The RP explained some of the services provided were more popular during particular times of the year. For example, up take of the health check service peaked in January and before the summer holiday period.

The pharmacy had processes to help identify high-risk medicines. And to provide counselling to people to support them in taking these medicines. The RP explained that checks associated with monitoring for medicines such as lithium, methotrexate and warfarin were normally completed verbally. Opportunities to record details of these checks on people's medication records was taken if a person had their monitoring record to hand. The pharmacy was completing a lithium audit and valproate audit on the date of inspection. And results from the lithium audit identified people taking the medicine received regular monitoring checks. No people in the valproate pregnancy prevention programme (PPP) target group had been identified through the valproate audit to date. Pharmacy team members had highlighted valproate on the dispensary shelves. And the pharmacy had warning cards available to issue to people in the high-risk group. The RP demonstrated additional steps being taken to manage the supply of methotrexate to people. The pharmacy only stocked 2.5mg tablets. And it recorded receipt and supply of its methotrexate. The RP explained these additional risk management steps had been

introduced following a briefing from the superintendent pharmacist's team.

A dispenser demonstrated audit trails in place for the pharmacy's managed repeat prescription service. This allowed team members to check the medication prescribed was correct prior to dispensing prescriptions. The pharmacy ordered prescriptions for people receiving the multi-compartment compliance pack service. And checks were made at the point of ordering a prescription to ensure stock to fill the pack was segregated into the persons individual basket. Every person receiving the service had a simple record in place identifying their medicine regimen. And a member of the team checked prescriptions against the sheet and medication record prior to assembling packs. Changes to medication regimens were seen to be clearly recorded on people's medication records. A sample of assembled packs contained descriptions of the medicines inside to help people identify them. And full dispensing audit trails were provided on each pack. The RP reported that patient information leaflets were provided at the beginning of each four-week cycle of packs. The only assembled packs on the date of inspection were mid-cycle supplies. Pharmacy team members explained how the small number of people receiving this service helped them to monitor collection of the packs. And they explained how they would share any concerns with medication compliance with surgeries if necessary.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. And it used the prescription throughout the dispensing process when the medicine was later supplied.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. The RP discussed changes to medicine packaging introduced due to the Falsified Medicine Directive (FMD). But the pharmacy had no equipment in place to support the team in complying with FMD requirements. The RP was aware of the pharmacy's head office completing some work associated with FMD. But no dates relating to implementation of equipment or training had been provided to the pharmacy to date. The pharmacy team received safety alerts and drug recalls via email. It acted upon these alerts in a timely manner and kept a copy for reference purposes. Some copies of alerts were annotated with details of medicines the pharmacy had returned to its wholesalers following a recall.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This meant the RP could supervise sales taking place and was able to intervene if necessary. The pharmacy stored medicines in the dispensary in an organised manner and within their original packaging. The pharmacy team followed a date checking rota to help manage stock and it recorded details of the date checks it completed. Short-dated medicines were identifiable. The team annotated details of opening dates on bottles of liquid medicines which had shortened expiry dates once opened. No out-of-date medicines were found during random checks of dispensary stock. Medical waste bins, sharps bins and CD denaturing kits were available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in a secure cabinet. Medicine storage inside the cabinet was orderly. There was designated space for storing patient returns, and out-of-date CDs. Assembled CDs were held in clear bags. And prescriptions for both CDs and cold chain medicines were highlighted with stickers. The pharmacy's fridge was clean and stock inside was stored in an organised manner. The pharmacy team monitored fridge temperatures. And recorded these within the safe and legal diary. A sample of the diary confirmed the fridge was operating between two and eight degrees Celsius as required.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors it equipment to ensure it remains in safe working order. And pharmacy team members act with care by using the pharmacy's facilities and equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. Pharmacy team members also had access to the company intranet and the internet which provided them with further resources. Clean, crown stamped measuring cylinders were in place for measuring liquid medicines. And these included separate measures for use with methadone. The pharmacy had clean counting equipment for tablets and capsules. Pharmacy team members had access to appropriate equipment for assembling medicines in multi-compartment compliance packs.

The pharmacy's electrical equipment had been safety checked in June 2019. The RP reported that the pharmacy's blood pressure machine was replaced every couple of years. Pharmacy team members calibrated the pharmacy's glucometer and cholesterol machine weekly. And they kept records of these checks. Equipment to support the vaccination and health check services was readily available in the consultation room.

The pharmacy's computers were password protected. And information on computer monitors was protected from unauthorised view due to the layout of the pharmacy. Pharmacy team members used NHS smart cards to access people's medication records. The pharmacy stored bags of assembled medicines in a retrieval system to the side of the dispensary. The pharmacy's telephone handset could be used cordlessly. This meant pharmacy team members could move out of ear-shot of the public area when having confidential conversations with people over the telephone.

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.