General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Off Yiewsley High Street, Yiewsley, WEST DRAYTON, Middlesex, UB7 7QP

Pharmacy reference: 1107231

Type of pharmacy: Community

Date of inspection: 29/11/2019

Pharmacy context

A supermarket pharmacy on a busy main road on the edge of Yiewsley town centre. As well as NHS essential services the pharmacy has an extended-hours dispensing service. And provides medicines in multi-compartment compliance packs for a small number of people living in the community. Other services include; Medicines Use Reviews (MURs), New Medicines Service (NMS) and health checks including blood pressure checks, diabetes checks, BMI and cholesterol checks. The pharmacy also provides medication for erectile dysfunction and meningitis vaccinations and malaria prophylaxis for travel and seasonal flu. The pharmacy also provides prescription services for substance misuse clients.

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	Good practice	1.1	Good practice	The pharmacy team is good at recognising what could cause a mistake and putting measures in place to prevent it.
		1.2	Good practice	Team members are good at sharing information and learning from what could go wrong to help reduce the chance of making mistakes in future.
		1.3	Good practice	Team members have a good understanding of their roles and responsibilities.
2. Staff	Standards met	2.5	Good practice	Team members work well together. They are good at supporting one another, so they can maintain and improve the quality of services..
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Good practice	4.2	Good practice	The pharmacy is good at ensuring that services are provided safely and effectively.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

The pharmacy's working practices are safe and effective. Its team members have a good understanding of their roles and responsibilities. They listen to people's concerns and keep people's information safe. Team members discuss any mistakes they make. They are good at sharing information and learning from what could go wrong to help reduce the chance of making mistakes in future.

Inspector's evidence

The pharmacy had procedures for managing risks in the dispensing process. Staff worked under the supervision of the responsible pharmacist (RP), whose sign was displayed for the public to see. They had standard operating procedures (SOPs) to follow, and, it was clear that team members understood those relevant to their roles. The team had procedures for managing risks in the dispensing process. It used a triple checking system, where items were checked three times; during dispensing, accuracy checking, and handing out. The third check, at the handing out stage had recently prevented a mistake between omeprazole tablets and capsules.

All incidents, including near misses, were discussed at the time and recorded. Near misses and errors were discussed to highlight any mistakes and reduce the chance of reoccurrence. If they made a mistake, team members asked the pharmacist to check the items they selected for the next five prescriptions before dispensing them. Staff were also required to double check spilt pack quantities with a colleague to help avoid a quantity error. Team members had read and signed a briefing note after a recent mistake between Toujeo Double star insulin pens and Toujeo Solostar insulin pens. In the fridge, a warning label had been placed in front of Toujeo insulin products to help prevent selection of the wrong one.

Near misses were reviewed and discussed weekly in 'Team 5' meetings. They were reviewed and discussed to prevent mistakes being repeated and to help the team learn and improve. The RP said that the person making the near miss was required to look at what they had dispensed in order to identify the mistake themselves and identify what they could do differently next time. Staff had also discussed the potential for error when dispensing different forms of the same drug such as ramipril tablets and ramipril capsules, and omeprazole capsules and omeprazole GR tablets. The team also shared information with colleagues in other stores. And, had taken steps to reduce the risks associated with 'look-alike-sound-alike' drugs (LASA)s. They had placed brightly coloured warning cards in front of products such as sertraline and sumatriptan, prednisolone and propranolol. Overall, the team had not had many mistakes to report.

The pharmacy team had a positive approach to customer feedback. A previous survey demonstrated a very high level of customer satisfaction. But a small number of people had identified areas where the pharmacy could do better, including the quality of the waiting area, waiting times and the provision of healthy living advice. So, staff had worked on reducing waiting times by trying to keep enough stock of commonly prescribed items and continued to provide healthy living advice when appropriate. The area manager was reviewing seating options which would not pose a trip hazard to other customers. The team described how, when costs and availability allowed, they ordered the same brands of medicines for certain people to help with compliance. Customer preferences included the Teva brand of diazepam and temazepam. The team added notes to individual patient medication records (PMRs) to act as a

reminder for themselves when dispensing and checking items for these patients.

The pharmacy had professional indemnity and public liability arrangements in place until the end of July 2020 when insurance would be renewed for the following year. Insurance arrangements were there to provide insurance protection for staff and customers. All the necessary records were kept and were generally in order including those for controlled drugs (CDs), private prescriptions, unlicensed 'Specials' and the responsible pharmacist (RP) record. Records were kept for patient returned and destroyed CDs, to ensure that they were accounted for. Records for Emergency Supplies were generally in order although several did not give clear reason for supply.

Staff were aware of the need to protect patient confidentiality. Discarded patient labels and other patient sensitive documents were put into identifiable confidential waste bags. Once full, these were sealed, ready for collection and disposal by a contracted waste disposal company. Staff been trained on information governance and had read a confidentiality agreement. Prescriptions were stored such that names and addresses could not be seen from the customer area. Staff were aware of the importance of safeguarding. Pharmacists had completed training to CPPE level 2, and all staff had undergone Tesco safeguarding training. Contact details for the relevant safeguarding authorities were available online and there was guidance on how to report a safeguarding concern on the wall. The team had not had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively. Team members work well together. They are good at supporting one another, so they can maintain and improve the quality of services. They are comfortable about providing feedback to employers and are involved in improving the pharmacy's services.

Inspector's evidence

The pharmacy had three regular RPs; the pharmacy manager, duty manager and regular part-time pharmacist. The pharmacy also had regular locums to cover additional shifts when required. The rest of the team consisted of two full-time dispensing assistants and three part time dispensing assistants. On the day of the inspection the RP worked on her own for the first two hours with a dispensing assistant arriving at 9am and another at 9.15am. The pharmacy manager arrived towards the end of the inspection. The daily workload of prescriptions was in hand and customers were attended to promptly.

The dispensing assistant said she had regular informal discussions with her colleagues and felt able to raise concerns with them. Team members were observed to work well together. It was evident that they could discuss matters openly, and they were seen assisting each other when required. She described how she and the other dispensing assistants had suggested that they should keep a selection of popular items which had been removed from the supermarket's planogram. Dispensing staff had also suggested that they clear out stocks of patient information leaflets, which they were no longer using, to provide additional storage space for dispensing stock. Staff had regular performance reviews. They also had regular training through the Tesco online training facility. They had recently renewed training on SOPs and safeguarding. Staff could access the online training site to keep their knowledge up to date.

When the regular pharmacists were on duty there was a period of double cover for four hours which allowed each pharmacist to have break. The overlap time also allowed for provision of services such as MURs and flu vaccinations, whilst minimising disruptions to the dispensing service. The pharmacist was able to make her own professional decisions in the interest of patients and offered services such as an MUR when she felt it beneficial for someone. All pharmacists were targeted with managing the daily workload and to provide additional services when it was appropriate to do so. The pharmacist administered flu vaccinations to two people during the inspection.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, tidy and organised. They provide a safe, secure and professional environment for people to receive healthcare services.

Inspector's evidence

The pharmacy was located on a run of wall space at the rear of the store, adjacent to general healthcare products. This helped patients to obtain all their medicines without too much inconvenience. When they could, staff would often help customers find the items they needed. The pharmacy had a traditional layout with the counter at the front and the dispensary behind. It appeared to have an adequate amount of work surface and storage capacity. There was a five to six-metre run of dispensing bench to one side and a three-metre run of dispensing bench to the other. The longer dispensing bench was used for walk-in dispensing and all accuracy checking. The other was used for storing incomplete prescriptions (Owings) and prescriptions with queries. The pharmacy was tidy and organised. Work surfaces and shelves were well used without unnecessary clutter. Staff tidied away stock and paperwork as soon as they had finished with them. Stock was stored in an organised fashion. Sinks, floors, and work surfaces were all clean. The pharmacy was bright and well ventilated with temperature control systems in place and had a professional appearance.

The consultation room was at the side of the counter, within easy access of the dispensary. The room was a sealed unit to ensure that conversations held in the room could not be overheard. When not in use, the consultation room door was kept locked via a coded keypad to prevent unauthorised access. There was seating outside the room for waiting customers. Access to the dispensary was at the discretion of the pharmacist. And all authorised non-pharmacy staff had signed a confidentiality agreement.

Principle 4 - Services ✔ Good practice

Summary findings

The pharmacy makes its services available to everyone. The pharmacy is good at ensuring that services are provided safely and effectively. Members of the pharmacy team give people the advice and support they need to help them use their medicines safely and properly. In general, the pharmacy manages its medicines safely and effectively. The pharmacy's team members check stocks of medicines regularly to make sure they are in date and fit for purpose. They store medicines appropriately and dispose of waste medicines safely.

Inspector's evidence

The store had signage outside to let people know it had a pharmacy. And, inside, it had signs at the top of the escalator at the entrance and in the healthcare area. It had further signage on the wall above the pharmacy. There was a list of pharmacy services on the wall outside the consultation room, and a small range of health information leaflets. Services were also listed on the NHS website. The store was laid out with wide clear aisles which meant that wheelchair users could access pharmacy services and there was a repeat prescription collection service for a small number of people.

In general, staff appeared to be providing services in accordance with standardised procedures. CDs were audited on a regular basis as per procedure. And a random check of CD stock (Zomorph 30mg capsules) indicated that the running balance quantity in the register, was correct. Dispensing labels were initialled by the person dispensing and the person checking, to provide a dispensing audit trail, as per the SOP. The pharmacy had procedures for targeting and counselling all patients in the at-risk group, taking sodium valproate. Staff said that, where appropriate, they would include valproate warning cards with prescriptions. Packs of sodium valproate in stock bore the updated warning label. All patients taking valproate, had been identified and appropriately counselled. Flu vaccines were administered in accordance with an up-to-date PGD and SOP. Patients were asked for their consent and asked to sign a consent form. The pharmacy kept records of all consultations and details of the product administered. The pharmacy had procedures for dealing with cases of anaphylaxis.

Medicines were obtained from licensed wholesalers and stored appropriately. Wholesalers used included Oakwood, AAH, Alliance Unichem and Phoenix. Unlicensed 'Specials' were obtained from Lexon. Stock was generally stored in a tidy, organised fashion. A CD cabinet and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and recorded daily. Methotrexate tablets had been moved to a separate basket away from normal stock to alert staff and prompt them to take extra care when dispensing. All stock was regularly date checked and records kept. But the pharmacy was not yet scanning products with a unique barcode in accordance with European Falsified Medicines Directive (FMD) requirements.

Waste medicines were disposed of in the appropriate containers and collected by a licensed waste contractor. Staff had a list of hazardous waste for to refer to, to help ensure that all waste medicines were disposed of appropriately. And it had a separate container and separate disposal arrangements for cytotoxic medicines. Drug recalls and safety alerts were acted upon promptly. Records were kept for recalls of items which the pharmacy stocked. None of the affected stock had been identified in the recent recalls for paracetamol 500mg tablets.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And, it uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had a CD cabinet for the safe storage of CDs. The cabinet was secured into place in accordance with regulatory requirements. The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures and tablet triangles were of the appropriate BS standard and generally clean, although one triangle had a slight dusty residue. Precautions were taken to help prevent cross contamination by using a separate triangle for counting loose cytotoxic tablets. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris. CD denaturing kits were used for the safe disposal of CDs. The pharmacy team had access to a range of up-to-date information sources such as hard copies and the on-line BNF and BNF for children. They also used the drug tariff, and the NPA advice line service and had access to a range of reputable online information sources such as the NHS, NICE and EMC.

The pharmacy had two computers in the dispensary and a lap top in the consultation room. Both dispensary computers had a PMR facility. All computers were password protected and were out of view of patients and the public. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was collected for safe disposal. Staff used their own smart cards when working on PMRs. They used their own smart cards to maintain an accurate audit trail and to ensure that access to patient records was appropriate and secure.

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.