General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Longcauseway, Farnworth, BOLTON, Lancashire, BL4 9LS

Pharmacy reference: 1107852

Type of pharmacy: Community

Date of inspection: 02/10/2019

Pharmacy context

This pharmacy is located at the rear of a supermarket on the edge of the town. People who use the pharmacy are mainly from the local area but some are from other parts of Greater Manchester. The pharmacy stays open for 100 hours per week, opening early in the morning and closing late in the evening. The pharmacy mainly dispenses NHS prescriptions and sells a range of over-the-counter medicines. It offers a range of health checks and provides flu and meningitis vaccinations.

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	1.2	Good practice	The pharmacy records and analyses adverse dispensing incidents to identify learning points which it incorporates into day to day practice to help manage future risks.
2. Staff	Good practice	2.2	Good practice	The pharmacy team members have the appropriate skills, qualifications and competence for their role and the pharmacy supports them to address their ongoing learning and development needs.
		2.4	Good practice	Team work is effective and openness, honesty and learning is embedded throughout the organisation.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	People can access a wide range of services over extended hours, and health and wellbeing are promoted to the community.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally manages risks and acts to improve patient safety. It keeps the records required by law and keeps people's private information safe. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. And they complete training so they know how to protect children and vulnerable adults.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their role. They were wearing uniforms and had been provided with name badges showing their role. The name of the responsible pharmacist (RP) was displayed as per the RP regulations.

Members of the pharmacy team completed a 'Pharmacy safe and legal record' which contained daily and weekly checks. For example, checks included ensuring the RP notice was on display, the CD cabinet was locked, CD keys secure and the fridge temperature was recorded. Any next steps were checked to ensure they had been completed. The team had completed training on what was included in a safe and legal audit and there had been an external safe and legal audit the previous week. The pharmacy was found to be fully compliant. A business continuity plan was in place which gave guidance and emergency contact numbers to use in the case of systems failures and disruption to services.

Near misses were recorded on a near miss log, reviewed weekly and discussed with the team. Next steps were documented on the log. For example, Glucophage had been separated from generic metformin following near misses. Dispensing incidents were reported on the online pharmacy incident reporting system and a report sent to the regional pharmacy manager (RPM) and a copy filed in the pharmacy. Root cause analysis and next steps were completed to document learning points. For example, fluoxetine 20mg was dispensed instead of 30mg so an alert was added to the patient medication record (PMR) system so that every time fluoxetine was labelled an additional warning label was produced which said check strength. The RPM supported the pharmacy with next steps if necessary. 'Safety starts here' bulletins were received from head office every four weeks, read out to the team, discussed and then filed. For example, issues such as the alcohol level in ranitidine solution was brought to the attention of the team. Look-alike and sound-alike drugs (LASAs) were pointed out, highlighted with caution labels and separated so extra care would be taken when selecting these. For example, amitriptyline 50mg and atenolol 50mg and amlodipine 10mg and amitriptyline 10mg. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out. A 'Safety starts here' notice board was in the dispensary indicated 507 days since the last reportable incident. 'Healthcare weekly news' were issued by head office covering current professional issues, such as the types of flu vaccinations which were licensed for different age ranges. It highlighted the risk of people claiming to be over 65 to obtain a free vaccination but them being give the incorrect type of flu vaccination.

A dispenser described how she would deal with a customer complaint which was to involve the duty

pharmacy manager if required . The pharmacy manager said he would refer it to the RPM if necessary and report it on the online reporting system. The pharmacy did not have a complaints notice or leaflet so people might not be aware of the complaints procedure or who to report concerns to. The dispenser said people often went to the stores customer service desk if they had a complaint and the store manager would then come and discuss the incident with the pharmacy manager. The pharmacy manager confirmed that the store manager, who was not a pharmacist, would not challenge a professional decision although he would expect the pharmacist to be able to justify the decision. A customer satisfaction survey was carried out annually. The results were on display in the consultation room and available on www.NHS.uk website. Areas of strength (91-93%)were cleanliness of the pharmacy, staff overall and service received from pharmacist and staff. An area identified which required improvement (8.5% dissatisfied) was the comfort and convenience of the waiting area. There were two plastic chairs in the waiting area. The pharmacy manager said no changes had been made as a result of the survey.

Indemnity Insurance arrangements were in place. Private prescription and emergency supply records, the RP record, and the controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

All members of the pharmacy team had read and signed documents in the information governance (IG) file which included information about confidentiality. Confidential waste was collected in designated red bags then sealed and taken to be stored in the stores confidential room before destruction with the rest of the stores confidential waste. The trainee dispenser correctly described the difference between confidential and general waste. Assembled prescriptions awaiting collection were not visible from the medicines counter. Paperwork containing patient confidential information was stored appropriately. A statement that the pharmacy complied with the NHS Code of Confidentiality was printed in the pharmacy leaflet and a privacy statement was on display in line with the General Data Protection Regulation. Consent was obtained when Summary Care Records (SCR) were accessed. This was routinely completed before carrying out flu vaccination so allergies could be checked.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. Other staff had completed safeguarding training on the Tesco’s online training site and this had been recorded on their training records. The dispenser said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. There was a safe guarding policy and the contact numbers of who to report concerns to in the local area. The pharmacy manager did not think there was a written chaperone policy but would ask people using the consultation room if they would like the person they arrived with to accompany them. There was nothing on display highlighting this to the people, so people might not realise this was an option. Members of the pharmacy team had completed dementia friends training and so had a better understanding of patients living with this condition.

Principle 2 - Staffing ✔ Good practice

Summary findings

Team members are well trained and work well together. The pharmacy encourages them to keep their skills up to date and supports their development. They are comfortable providing feedback to their manager and receive feedback about their own performance. The pharmacy has enough team members to manage its workload safely. Its staffing rotas enable it to have good handover arrangements and effective communication. It enables the team members to act on their own initiative and use their professional judgement to benefit people who use the pharmacy's services.

Inspector's evidence

There were two pharmacists , an NVQ2 qualified dispenser (or equivalent) and a trainee dispenser on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and the patients. A 'heat map' which showed the workload during the day, was used to ensure minimum staffing levels. Planned absences were organised in a holiday diary so that not more than one person was away at a time. Absences were covered by re-arranging the staff rota which was planned four weeks in advance. There was flexibility within the team and staff hours were usually replaced on a like-for-like basis. There was a separate rota for pharmacist cover with ten hours of pharmacist overlap planned in each week, allowing the completion of management activities without impacting on the pharmacist's professional duties. The pharmacy manager said because the pharmacy was open 100 hours per week there were often quiet periods when paperwork could be completed, such as early in the morning and late in the evening.

Members of the pharmacy team used the Tesco's online training website to ensure their training was up to date. Members of the pharmacy team carrying out services had completed the appropriate training. The pharmacy manager confirmed he had completed face-to-face training and annual online refresher training on flu vaccination which included basic life support and vaccination technique. There were training record cards for all members of the team and specific 'Welcome to pharmacy' training had been completed. Pharmacy team members were given some protected training time and also completed training when the pharmacy was quiet. The records showed regular training had been completed in addition to accredited training courses.

The pharmacy team were given formal reviews and appraisals or touchpoint conversations where performance and development were discussed. Informal meetings were held weekly where a variety of issues were discussed. The trainee dispenser said he would feel comfortable talking to the pharmacy manager about any concerns he might have. He said the staff could make suggestions or criticisms informally. For example, suggestions to promote the text (SMS) service where people were sent a text to let them know their prescription was ready to collect, or if the pharmacy wanted to contact the patient for any reason. There was a whistleblowing policy available online. The pharmacy manager said he felt comfortable reporting errors and felt that the RPM supported the team in learning from mistakes and making robust next steps. There was a management conference call every week and 'Safety starts here' was always on the agenda.

One of the pharmacists confirmed he felt empowered to exercise his professional judgement and could

comply with his own professional and legal obligations. For example, refusing to sell a pharmacy medicine because he felt it was inappropriate. He said targets were set for Medicines Use Reviews (MURs), New Medicine Service (NMS) and flu vaccinations and they were very important in the organisation. But he didn't feel targets ever compromised patient safety and he didn't feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for people to receive healthcare. The pharmacy has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy premises were clean and well maintained. There was a small area in front of the medicine counter which was free from obstructions and professional in appearance. There was a waiting area at the side of the counter with two chairs. The temperature and lighting were adequately controlled. The pharmacy had been fitted to a good standard when it opened, and the fixtures and fittings were in good order. Maintenance problems were reported to the instore maintenance team and the response time was appropriate to the nature of the issue. For example, a defective light was repaired the following day after it was reported.

The pharmacy team used the store's facilities which included a staff canteen and WCs with wash hand basin and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. A hand washing notice was displayed above the sink. Hand sanitizer gel was available.

The consultation room was equipped with a sink, and was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign above the door. A member of the pharmacy team explained they would use this room when carrying out the services and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a wide range of healthcare services which are easy for people to access. It gives advice to people about healthy living and where they can get other support. Services are generally well managed, so people receive appropriate care. The pharmacy sources, stores and supplies medicines safely. And it carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy counter and consultation room were accessible to all, including patients with mobility difficulties and wheelchair users. There was an automatic door into the supermarket. There was a hearing loop in the pharmacy and a sign showing this. Services were advertised inside the pharmacy and listed in the practice leaflet. The pharmacy team were clear what services were available and where to signpost to a service not offered. For example, needle exchange. A folder was available containing relevant signposting information which could be used to inform patients of services and support available elsewhere.

There was a small range of healthcare leaflets on display and a table with healthy living information promoting diabetes screening. People were risk assessed for diabetes and those at high risk referred to their GP or diabetes nurse. There was a healthy living event planner and providing healthy living advice was recorded in the form of a tally chart to give an indication of the effectiveness of the health promotional activities. A few people had shown an interest in the diabetes screening and the pharmacy was planning a special day to increase awareness about diabetes. The pharmacy manager said a dedicated site would be set up at the front of the store to promote this. He said a similar event had taken place the previous year and had been very popular, when between 50 and 100 people took part and were provided with information. Patients with diabetes presenting prescriptions at the pharmacy were asked if they had a recent foot check and attended retinopathy screening, and reminded of the importance of this.

The pharmacy offered a repeat prescription ordering service. Patients indicated their requirements a month in advance when they collected their medication. Requirements were checked again at handout and any unrequired medicines were retained in the pharmacy and the prescription endorsed as not dispensed. This was to reduce stockpiling and medicine wastage.

Space was quite limited in the dispensary, but the work flow was organised into separate areas with a designated checking area. The dispensary shelves were reasonably neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. ‘MUR’ stickers were used to highlight patients who would benefit from this service. Patients prescribed high-risk medicines such as anticoagulants, non-steroidal anti-inflammatory drugs and valproate were targeted for extra checks and counselling. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out and two patients in the at-risk group had been identified. There was a note on one of these patient’s records to have a discussion about pregnancy prevention

and check they had been made aware of the risk, but there was nothing to confirm this had been carried out. There were no notes on the other patient's records and the pharmacy manager could not confirm if this had taken place. The pharmacy manager could not locate the valproate information pack and care cards but said he would obtain them to ensure people in the at-risk group were given the appropriate information and counselling.

There were around eight patients who received their medication in multi-compartment compliance aid packs. These were well organised but did not always have a complete audit trail for communications with GPs and changes to medication, so it was not always clear who had confirmed the changes or the date they had been made. A dispensing audit trail was completed, and medicine descriptions were usually included on the labels/packaging to enable identification of the individual medicines. The pharmacy team admitted packaging leaflets were not always supplied, despite this being a mandatory requirement, so patients and their carers might not be able to easily access required information about their medicines. Disposable equipment was used.

The dispenser knew what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled. CDs were stored in a CD cabinet which was securely fixed to the floor. The keys were under the control of the responsible pharmacist during the day and stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits.

Recognised licensed wholesalers were used to obtain medicines. Patients details were not being retained in the pharmacy when medicines had been ordered from 'Specials', but the pharmacy manager believed this was being recorded at head office and no longer a requirement in branch. No extemporaneous dispensing was carried out. The pharmacy was not compliant with the Falsified Medicines Directive (FMD). They had the software needed to comply but not the hardware, so they were not scanning to verify or decommission medicines before handing them out. Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short dated stock was highlighted. Dates had been added to most opened liquids with limited stability, although one bottle of Oramorph solution had not been dated when opened. The pharmacy manager said he would not use it as he did not know if it had been opened within the required three months. He said he would put it with the expired medicines which were segregated into designated bins. Alerts and recalls were received via messages from the online system. These were read and acted on by a member of the pharmacy team and then filed to provide assurance that the appropriate action has been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe and use it in a way that protects privacy.

Inspector's evidence

Current copies of British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information. There was a clean medical fridge. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested. There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were marked and used for methadone solution. The pharmacy had a range of clean equipment for counting loose tablets and capsules. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.