General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Town Gate Retail Park, Birmingham Road, DUDLEY, West Midlands, DY1 4RP

Pharmacy reference: 1108487

Type of pharmacy: Community

Date of inspection: 20/05/2024

Pharmacy context

This is a community pharmacy located within a large Tesco supermarket in Dudley, West Midlands. The pharmacy is open extended hours over seven days. It dispenses both NHS and private prescriptions and sells a range of over-the-counter (OTC) medicines. And it provides NHS funded services such as the Pharmacy First service and blood pressure testing.

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 adequately manages the risks associated with its services to make sure people receive appropriate care. Members of the pharmacy team can access written procedures to make sure they work safely, and they complete tasks in the right way. They discuss their mistakes so that they can learn from them. And team members understand their role in protecting vulnerable people and they keep people's personal information safe.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. SOPs were issued by head office and the latest versions were available on the company intranet. The pharmacy had a printed copy of the SOPs and another set saved to the computer. Both of these versions had been superseded and were not the same as the ones available on the intranet, but the team members were not aware of this. They were removed from the dispensary during the inspection to be archived. Training was recorded to the team member's individual electronic learning (eLearning) account. This was quite a new process and the team members that were on duty during for the inspection had not yet had the opportunity to undertake training on the new SOPs. They did not appear confident in how to use the eLearning platform to record their training or know how to access management reports and data.

A near miss log was available but recording was sporadic, suggesting that they were not always recorded. Near misses were discussed with the dispenser involved to help make sure they learnt from the mistake, and any learning was shared with the team. The team demonstrated examples of medicines that had been highlighted to reduce the risk of them being selected in error during the dispensing process. LASA (look alike, sound alike) medicines were also labelled. A dispensing assistant explained how she would handle a dispensing error and gather as much information as possible from the person. The pharmacist manager was then responsible for investigating and reporting the error. Safe and legal checks were carried out daily and recorded electronically. These were usually carried out by the pharmacist manager and different checks were completed on a daily, weekly and monthly basis. The pharmacy team carried out clinical audits in accordance with the NHS Pharmacy Quality Scheme requirements.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A member of the team answered hypothetical questions related to requests for over-the-counter high-risk medicines, such as co-codamol or sleeping aids correctly. Pharmacy staff were wearing uniforms and name badges. The RP was observed making himself available to discuss queries with people and giving advice when he handed out prescriptions.

A complaints procedure was in place. A dispensing assistant explained the process for handling a complaint or concern. She said that she would speak to the person first and would try to resolve the issue, and would refer to the pharmacist manager, customer services desk or provide contact details for head office if the complaint was unresolved. People occasionally complained to the in-store customer

service team when a member of the pharmacy team had used their professional judgement and refused a sale of a medicine when they thought it was inappropriate, for example, codeine containing medication. The team said that a department manager would usually ask the pharmacist about their decision so that they could explain it to the customer, but they did not put any pressure on the pharmacist to sell medicines.

The pharmacy had professional indemnity insurance arrangements in place. The responsible pharmacist (RP) notice was clearly displayed, and the RP log complied with requirements. Controlled drug (CD) registers were in order and a random stock check matched the balance recorded in the register. A patient returned CD register was in place. Private prescriptions records were in order. Specials records were maintained with an audit trail from source to supply.

Confidential waste was stored separately from general waste and destroyed securely offsite. The pharmacy team members had their own NHS smartcards and they confirmed that passcodes were not shared. The pharmacy team had completed training on safeguarding and data protection as part of their mandatory compliance training. The pharmacy team understood what safeguarding meant and safeguarding contacts were available. The dispensing assistants gave examples of types of concerns that they might come across and correctly described what action they would take.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and the services that it provides. The team members plan absences in advance, so they always have enough cover to provide the services. They work well together in a supportive environment and can raise concerns and make suggestions.

Inspector's evidence

The pharmacy team comprised of two pharmacist managers, seven trained dispensing assistants, a trainee dispensing assistant and three medicine counter assistants. Holidays were booked in advance and cover was provided by other staff members as required. One of the pharmacist managers prepared staffing rotas approximately a month in advance so that cover could be arranged. The pharmacy had an extended hours NHS contract and locum pharmacists worked when the pharmacist managers were off.

Pharmacy team members completed ongoing training provided by Tesco which aligned to the launch of new services, NHS Pharmacy Quality Scheme (PQS), annual compliance training and pharmacy updates. Due to the extended opening hours and different shift patterns, written communication and small group briefings helped make sure that all members of staff were updated on topics such pharmacy business, company updates, ongoing stock issues and daily tasks.

The pharmacy team worked well together during the inspection and team members were observed helping each other with tasks. Team members said that they could raise concerns or suggestions with the pharmacist managers or the store manager and felt they were responsive to feedback. The RP was observed making himself available to discuss queries with people and giving advice when he handed out prescriptions. The pharmacist manager said there was a reasonable expectation that he would offer professional services, such as the NHS Pharmacy First service and the NHS hypertension case-finding service if a suitable patient was identified.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. The pharmacy team uses a consultation room for services and if people want to have a conversation in private.

Inspector's evidence

The pharmacy was smart in appearance and appeared to be well maintained. Any maintenance issues were reported to the maintenance department in store. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter. A secure area of the stockroom was available for the pharmacy team to use as additional storage space.

The dispensary was an adequate size for the services provided and an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the worktops. There were two private soundproof consultation rooms which were used throughout the inspection. The consultation rooms were professional in appearance. The doors to the consultation rooms remained locked when not in use to prevent unauthorised access.

The dispensary was clean and tidy and was cleaned by pharmacy staff and an in-store cleaner. The sinks in the dispensary and staff areas had hot and cold running water, hand dryer and hand soap were available. The store had an air-cooling system which regulated the temperature. Lighting was adequate for the services provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. It manages its services and supplies medicines safely. The pharmacy obtains its medicines from licensed suppliers and stores them securely. People receive appropriate advice about their medicines when collecting their prescriptions.

Inspector's evidence

The pharmacy had step-free access from a large car park. The pharmacy was open long hours, including late nights, and Saturday and Sunday. The range of services provided was displayed and pharmacy leaflets were available for customers. The pharmacy staff used local knowledge and the internet to refer people to other providers for services that the pharmacy did not offer. Any people requesting a home delivery service or multi-compartment compliance packs were referred to other pharmacies in the area. The pharmacy had a hearing loop available.

The pharmacy offered the NHS Pharmacy First service. Posters were displayed advertising the service to people using the pharmacy. The team had undergone training and had read training materials. They had quick reference guides and the NHS PGDs (patient group directions) and supporting documentation had been printed for reference. The team had a separate stock of medicines that were available through Pharmacy First and regularly checked the stock levels to ensure the continuity of the service.

Prescriptions were dispensed in baskets with different colours used for different prescription types, for example, red baskets for waiting prescriptions. Dispensing baskets were also used to keep medication separate. Team members signed the ‘dispensed-by’ and ‘checked-by’ boxes on medicine labels, so there was a dispensing audit trail for prescriptions. A final ‘hand out’ check was done for every prescription, and this involved the pharmacist or dispenser checking the prescription again as an additional accuracy check.

Prescriptions were printed and labelled after they had been downloaded from the NHS spine and stored in an A-Z filing system awaiting assembly. Prescriptions were assembled when people came in to collect them. The stock was ordered when the prescription was labelled to reduce the chance of medicines being owed to people. The pharmacist managers had made the decision to delay assembling prescriptions until people came in to collect them as they had limited storage space for dispensed prescriptions, and they had noticed an increase in the number of prescriptions not being collected. Disassembling prescriptions created additional workload for the team, so they were trialling a new way of working in order to be more efficient.

Stickers or notes were attached to completed prescriptions to highlight people suitable for certain services or that needed fridge or CD items adding. The pharmacy team was aware of the additional counselling required for certain people prescribed valproate and stickers, leaflets and information were available to support counselling. The team were also aware of the additional counselling required for high-risk medicines, such as warfarin and methotrexate. Methotrexate was stored in a separate basket

to remind the team of the additional checks that they should make when dispensing it.

A random sample of dispensary stock was checked, and all the medicines were found to be in date. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in designated bins. Medicines were obtained from a range of licenced wholesalers. Drug recalls were received electronically.

The controlled drug cabinet was secure and a suitable size for the amount of stock that was held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridge was working within the required temperature range of 2°C and 8°Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. The pharmacy team stores and uses the equipment in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF) and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough computer terminals for the workload currently undertaken. A range of clean, crown stamped measures and counting triangles were available.

Equipment for clinical consultations had been suitably procured and was stored appropriately. Some of the equipment was single use, and ample consumables were available. Computer screens were not visible to members of the public. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.