

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Hammonds Farm, Jane Murray Way, BURGESS HILL, West Sussex, RH15 9QT

Pharmacy reference: 1111709

Type of pharmacy: Community

Date of inspection: 22/01/2020

Pharmacy context

This is a community pharmacy set within a busy supermarket on the outskirts of Burgess Hill. The pharmacy opens seven days a week. And most people who use it live in the town or the surrounding rural areas. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It provides multi-compartment compliance packs (compliance packs) to help a few people take their medicines. And it offers winter influenza (flu) vaccinations and a substance misuse treatment service. Its team can also take people's blood pressure (BP) and check their blood sugar and cholesterol levels.

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	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 has written procedures to help make sure its team works safely. It adequately monitors the safety of its services. It has appropriate insurance to protect people if things do go wrong. It mostly keeps all the records it needs to by law. And it asks people using its services for their views. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They identify and manage risks appropriately. They review the mistakes they make and learn from them to try and stop them happening again. They understand their role in protecting vulnerable people. And they generally keep people's private information safe.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) for the services it provided. And these were reviewed within the past two years. The pharmacy's team members were required to read, sign and follow the SOPs relevant to their roles. The team members responsible for making up people's prescriptions tried to keep the dispensing workstations tidy. They used baskets to separate people's prescriptions and to help them prioritise the dispensing workload. The pharmacy had systems to record and review dispensing errors and near misses. Members of the pharmacy team discussed individual learning points when they identified a mistake. And they reviewed their mistakes and took actions to try and stop them happening again. For example, they separated a few look-alike and sound-alike drugs to help reduce the risks of them picking the wrong product.

The pharmacy displayed a notice that identified the responsible pharmacist (RP) on duty. Staff wore name badges which identified their roles within the pharmacy. And their roles and responsibilities were described within the SOPs. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. They explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products to the pharmacist. A complaints procedure was in place and patient satisfaction surveys were undertaken annually. The pharmacy team asked people for their views. The pharmacy displayed the results of last year's patient satisfaction survey. Its practice leaflet told people how they could provide feedback about the pharmacy. And people's feedback led to the pharmacy team trying to keep people's preferred makes of prescription-medicines in stock.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, through the National Pharmacy Association (NPA). The pharmacy's RP records were adequately maintained. The controlled drug (CD) register was generally kept in order. Its running balance was checked regularly. But occasionally the address from whom a CD was received from wasn't always included in it. The nature of the emergency within the pharmacy's records for emergency supplies made at the request of patients didn't always provide enough detail for why a supply was made. The prescriber's details and the date of prescribing were sometimes incorrect within the private prescription records. The date an unlicensed medicinal product was obtained at the pharmacy wasn't always included in the pharmacy's 'specials' records.



The pharmacy displayed a notice next to its counter to tell people how their personal data was used and kept. The pharmacy had an information governance policy which its team needed to read and sign. It had arrangements to make sure confidential waste was collected and then sent to a centralised point for secure destruction. Its team stored prescriptions in such a way so people's names and addresses couldn't be seen by someone who shouldn't see them. But people's details weren't always removed or obliterated before patient-returned waste was disposed of. The pharmacy had some safeguarding guidance for its team. And contacts for safeguarding concerns were available too. Members of the pharmacy team were required to complete safeguarding training relevant to their roles. And they could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough people in its team. Members of the pharmacy team keep their skills and knowledge up to date. So, they can deliver safe and effective care. But they don't always have time set aside so they can train while they're at work. They use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy opened for 100 hours a week. It dispensed about 5,100 NHS prescription items a month. The pharmacy team consisted of a full-time pharmacist manager, two part-time pharmacists, a full-time dispensing assistant and four part-time trainee medicines counter assistants (MCAs). Two pharmacists, a dispensing assistant and one of the trainee MCAs were present during the inspection. The pharmacy relied upon its team, colleagues from other departments or locum staff to cover absences. The pharmacy's team members sometimes struggled to do all the things they needed to particularly when colleagues were away. But they supported each other so prescriptions were processed safely. And people were served promptly.

The pharmacists supervised and oversaw the supply of medicines and advice given by staff. A sales of medicines protocol was in place which the pharmacy team needed to follow. A member of staff described the questions she would ask when making over-the-counter recommendations and when she would refer people to a pharmacist. For example, requests for treatments for animals, infants, people who were pregnant or breastfeeding, elderly people or people with long-term health conditions. The pharmacy had an induction training programme for its team. People who worked in the pharmacy, including colleagues from other departments, needed to complete mandatory and accredited training relevant to their roles. Members of the pharmacy team discussed their performance and development needs with their line manager throughout the year and at colleague reviews. They were encouraged to ask questions and familiarise themselves with new products. They were also asked to complete online training to make sure their knowledge was up to date. But they tended to complete this in their own time as they were often busy managing the pharmacy's workload or helping people when at work. And there was only one computer terminal available in the pharmacy which was frequently in use.

Team meetings, one-to-one discussions and a 'WhatsApp' group were held to update staff and share learning from mistakes or concerns. Members of the pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. They knew how to raise a concern if they had one. And their feedback led to changes to the pharmacy's prescription retrieval system. They felt the targets set for the pharmacy could be challenging at times. And occasionally they felt under pressure to complete all the things they were expected to do. But they didn't feel their professional judgement or patient safety were affected by targets. Medicines Use Reviews and New Medicine Service consultations were only provided by a suitably qualified pharmacist when it was clinically appropriate to do so and when the workload allowed.





Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy has a room where people can have private conversations with members of the pharmacy team. And it provides an adequate and secure environment for people to receive healthcare. But it's small. So, its team members don't always have the space they need to work in.

Inspector's evidence

The pharmacy was behind the supermarket's checkouts. And it was set between a coffee shop and a travel money bureau. It was air-conditioned, bright, clean, secure and professionally presented. But it was small. And it had limited storage and workspace. So, its worksurfaces and floor often became cluttered when it was busy. The pharmacy had a consultation room for the services it offered and if people needed to speak to a team member in private. Conversations in the consultation room couldn't be overheard in the areas next to it. And it was kept locked when it wasn't being used to make sure its contents were kept secure. The pharmacy was cleaned by a cleaning contractor. But the cleaner wasn't left unsupervised in the pharmacy. The pharmacy's team members were also responsible for keeping the registered pharmacy area clean and tidy. The pharmacy's sinks were clean. And the pharmacy had a supply of hot and cold water. It also had appropriate handwashing facilities for its staff too.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. The pharmacy provides services that people can access easily. It offers flu vaccinations and keeps records to show that it has given the right vaccine to the right person. It gets its medicines from reputable sources and it stores most of them appropriately and securely. Members of the pharmacy team generally dispose of people's waste medicines properly. They mostly carry out the checks they need to. And they respond well to drug alerts or product recalls. So, people get medicines or devices which are safe.

Inspector's evidence

The supermarket had a large car park for people to use. It had automated doors and its entrance was level with the outside pavement. But the pharmacy didn't have a low-level counter. So, its team needed to make reasonable adjustments to help some people with mobility difficulties, such as wheelchair users, when they attended the pharmacy. The pharmacy was open most days of the year and it opened early and stayed open later than usual six days a week. The pharmacy's services were advertised in-store and were included in the pharmacy's practice leaflet. The pharmacy team knew what services the pharmacy offered and where to signpost people to if a service couldn't be provided. The pharmacy didn't offer a delivery service. So, people who couldn't attend its premises in person relied upon others to collect their medication.

The pharmacy provided a winter flu vaccination service. It had valid, and up-to-date, patient group directions and appropriate anaphylaxis resources in place for this service. It kept a record for each flu vaccination. This included the details of the person vaccinated and their written consent, an audit trail of who vaccinated them and the details of the vaccine used. The pharmacist often asked another team member to check that the vaccine they selected was the correct one before administering it. The pharmacy team made sure the sharps bin was kept securely when not in use. Some people chose to be vaccinated at the pharmacy rather than their doctor's surgery for convenience or because they were not eligible for the NHS service. Some members of the pharmacy team could take people's BP and check their blood sugar and cholesterol levels. But there wasn't much demand for these services. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And its team checked whether a medicine was suitable to be repackaged. The pharmacy's dispensing workflow was carefully managed to reduce the chances of staff making mistakes. Members of the pharmacy team followed the pharmacy's SOPs. They referred to prescriptions when labelling and picking products. And they initialled each dispensing label. Assembled prescriptions were checked by a pharmacist who was also seen initialling the dispensing label. And patient information leaflets needed to be supplied. Prescriptions were highlighted to alert staff when a pharmacist needed to counsel people and when CDs or refrigerated items needed to be added. But prescriptions weren't handed out to people until an additional accuracy check was done at the point of supply. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Valproate educational materials were available at the pharmacy.



The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer’s packaging. But a few medicines were found within inadequately labelled containers. These were promptly quarantined during the inspection. The pharmacy’s stock was subject to date checks, which were documented, and short-dated products were marked. The pharmacy stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius. And it also stored its CDs, which were not exempt from safe custody requirements, securely. A record of the destruction of patient-returned CDs was maintained. The pharmacy team was required to keep patient-returned and out-of-date CDs separate from in-date stock. Members of the pharmacy team were unsure about the requirements of the Falsified Medicines Directive (FMD). They weren’t decommissioning stock at the time of the inspection. The pharmacy’s SOPs hadn’t been revised to reflect the changes FMD would bring to the pharmacy’s processes. And the pharmacy team didn’t know when the pharmacy would become FMD compliant. The pharmacy had procedures for the handling of patient-returned medicines and medical devices. Patient-returned waste was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. The pharmacy had a pharmaceutical waste bin. But it didn’t have a receptacle for the disposal of hazardous waste, such as cytostatic and cytotoxic products. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they would take and demonstrated what records they kept when the pharmacy received a concern about a product.



Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure its equipment is kept clean and is appropriately maintained.

Inspector's evidence

The pharmacy had a range of glass measures. It had equipment for counting loose tablets and capsules too. And staff made sure the equipment they used to measure or count medicines was clean before using it. The pharmacy team had access to up-to-date reference sources. And it could contact the superintendent pharmacist's office or the NPA to ask for information and guidance. The pharmacy provided BP checks on request. And the BP monitor was replaced within the past year. The accuracy of the blood glucose and cholesterol monitors needed to be checked regularly. And calibration records were available to demonstrate this. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team checked and recorded the refrigerator's maximum and minimum temperatures regularly. Access to the pharmacy's computer and the patient medication record system was restricted to authorised team members and password protected. The computer screen was positioned so only team members could see it. A cordless telephone system was installed at the pharmacy to allow staff to have confidential conversations when necessary. The team members responsible for the dispensing process each had their own NHS smartcard. And they made sure it was stored securely when they weren't working.



What do the summary findings for each principle mean?

✓ **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.