General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Wyre Street, Padiham, BURNLEY, Lancashire, BB12 8DQ

Pharmacy reference: 1111907

Type of pharmacy: Community

Date of inspection: 19/07/2019

Pharmacy context

This is a community pharmacy inside a Tesco supermarket in Padiham, Burnley. It is open seven days a week. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions and provides a substance misuse service. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And offers services including medicines use reviews (MURs), flu vaccinations and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

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	2.2	Good practice	The pharmacy is good at supporting its team members to maintain and progress their knowledge and skills. It achieves this through continual training and performance appraisals
		2.5	Good practice	The pharmacy encourages its team members to get support and to provide feedback. And the team members use this feedback to improve the pharmacy's service.
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 adequate processes and written procedures to protect the safety and wellbeing of people who access its services. It keeps the records it must have by law and keeps people's private information safe. It is well equipped to protect the welfare of vulnerable adults and children. The pharmacy team members try to learn from any errors that they make while dispensing. And they take steps to make sure the errors are not repeated.

Inspector's evidence

The pharmacy was accessible from the grounds of the supermarket. It had an open plan retail area which led directly into the dispensary. The pharmacy had a private consultation room to the side of the retail counter. The pharmacist used the bench closest to the retail counter to do final checks on prescriptions. This helped her supervise and oversee sales of over-the-counter medicines and conversations between team members and people.

The pharmacy had a set of standard operating procedures (SOPs). These were kept in a ring binder. An index was available which made it easy to find a specific SOPs. The SOPs covered various pharmacy processes. For example, taking in prescriptions, dispensing and the dispensing of medicines in multi-compartmental compliance packs. The SOPs were last reviewed in June 2018 and due to be reviewed again in July 2020. A training record was seen. It showed which SOPs were relevant to each team member. And each team member had signed the record to show they had read and understood the contents of the SOPs. The pharmacy defined the roles of the pharmacy team members in each SOP. The SOP showed who was responsible for performing each task. The team members said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy had a process to report and record near miss errors that were spotted during dispensing. The pharmacist typically spotted the error and then informed the dispenser that they had made an error. The team members then discussed why the error had happened. The error was then rectified by the dispenser and then passed to the pharmacist for another check. The dispenser then made a record of the error into a near miss log. The records contained details such as the date and the type of the error. But the team did not always record the time of the error or why the error might have happened. And so, they may have missed out on some learning opportunities. The team was required to analyse the near misses each month for any trends and patterns. But the pharmacist said she had decided to analyse them each week instead. She said this was to make sure the errors were fresh in the team members minds when they came to discuss them. The team members discussed the findings each week. And they recently discussed quantity errors. They implemented a system to write down the quantity of the medicine they were dispensing, on the inside of the box they were to be dispensed in. The pharmacy used a similar process to record and report dispensing incidents. The pharmacy recorded such incidents electronically and kept the records for future reference. The records were also sent to the company head office for analysis. The pharmacy had recently supplied a person with the incorrect strength of their medicine. The pharmacy implemented a 'tick box' checking procedure to reduce the risk of errors happening again. The team members were required to 'tick off' the product name, strength and quantity on the package to confirm that it matched the prescription. The team also segregated the two strengths of the medicine to stop them being mixed up.

The pharmacy's complaints procedure was not advertised to people. And so, people may find it difficult to raise a concern or give feedback. The pharmacy completed a feedback survey each year. It asked people who visited the pharmacy to complete a questionnaire. The results of the latest survey were displayed in the consultation room. The participants of the survey had identified three areas of the pharmacy that could be improved. They were, the waiting area, the time taken to dispense prescriptions and the ability to have a private conversation with a team member. The team members were unable to make any significant changes to the waiting area due to a lack of space, but they ensured that the area was always clean and tidy. They also made sure they gave people realistic waiting times, so they could better manage their expectations. The team members said that they ensured that offered the consultation room to anyone who asked for some advice from a team member.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries made in chronological order. The pharmacy kept running balances and they checked them each week to make sure they were correct. The running balance of oxycontin 20mg tablets matched the physical stock. The pharmacy correctly used a CD destruction register for patient returned medicines. It also kept complete records of supplies from private prescriptions and emergency supplies. The pharmacy kept the certificates of conformity with complete details as required by the Medicines and Healthcare products Regulatory Agency (MHRA).

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. A privacy notice was on display in the retail area. The pharmacy had a data protection policy in place. The team members understood the importance of keeping people's information secure.

The regular pharmacist had completed training via the Centre for Pharmacy Postgraduate Education on safeguarding the welfare of vulnerable people. All the other team members had completed training through the Tesco Academy. The team members were able to describe the symptoms that would be of concern. The pharmacy did not have a policy on managing a safeguarding concern. And so, the team may not know how to effectively raise and manage a potential concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough suitably qualified and skilled pharmacy team members to deliver the services provided. The pharmacy assesses the team members rotas and has plans in place to help them during busy periods. And when there are absences. It is good at supporting team members to maintain and progress their knowledge and skills. It does this through continual training and performance appraisals. The pharmacy encourages its team members to get support and to provide feedback. And the team members use this feedback to improve the pharmacy's services.

Inspector's evidence

The regular pharmacist was on duty at the time of the inspection. And she was also the pharmacy manager. During the inspection two pharmacy assistants and a locum pharmacist supported the regular pharmacist. One of the assistants was training to become a pharmacy technician. The pharmacy also employed a second pharmacist, another pharmacy assistant and two counter assistants. The pharmacist said that she felt she had a good team who supported each other well. And she had enough team members to manage the dispensing workload. The two pharmacists organised and managed the team rotas each week. The pharmacy was able to call on the help of ‘multi-skillers’ during busy periods. The multi-skillers were employees of Tesco who worked in other parts of the supermarket such as the checkouts. They had received basic training on tasks such as date checking and taking in prescriptions. And they had read and signed the relevant SOPs. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy’s busiest period. The team members worked overtime to cover each other’s absences. The pharmacist had the support of another pharmacist for around one to two hours each day. This helped the pharmacist complete various tasks such as delivering services and private consultations.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks that they could and could not perform in the pharmacist’s absence.

The pharmacy supported its team members to regularly complete training modules. The modules were available through an online programme called Tesco Academy. Several modules were mandatory, and the team members were provided with time during working hours to complete them. The modules could also be completed voluntarily if a team member felt they wanted to learn about a specific process or healthcare topic. The team had recently completed training on the flu vaccination service which they were due to start in autumn.

The team held regular meetings and engaged in regular one-to-one conversations with the pharmacist as part of a structured appraisal process. The meetings and appraisals were an opportunity to discuss learning needs, dispensing accuracy and any feedback. The team members had discussed the most recent dispensing error. They had discussed how they could share ideas to prevent the error occurring again. The team members had decided to ensure they always used the ‘tick box’ checking procedure. And pharmacists were asked to use a red pen when checking to ensure it was easy to confirm that a

pharmacist had accuracy and clinically checked the prescription. The team also agreed that any locum pharmacists were told that they were not to self-check any prescriptions to reduce the risk of errors.

The team members said that they were able to discuss any professional concerns with the pharmacist or with the company head office. A company whistleblowing policy was in place. And so, the team could raise a concern anonymously. The pharmacy set several targets for its team to achieve. These included services and prescription volume. The team members said that the targets were reasonable and achievable. But they were not under any pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and adequately maintained. It has a sound-proof room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and portrayed a professional image. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. Other staff facilities were available at the rear of the building. There was a key coded gate that separated the pharmacy from the rest of the supermarket. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. It generally stores, sources and manages its medicines safely. And it identifies and manages its risks adequately. The pharmacy team members help people to safely take high-risk medicines. And they have identified, and managed various risks associated with dispensing medicines in multi-compartmental compliance packs.

Inspector's evidence

There was step-free access into the pharmacy. People who used the pharmacy could use the supermarket car park. The pharmacy advertised its services and opening hours around the pharmacy counter. Seating was provided for people waiting for prescriptions. Large print labels were provided on request. The pharmacy also had a hearing loop. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. The pharmacy did not offer a delivery service, but the team members were aware of the local pharmacies that did. And they directed people who wanted a delivery service, to these pharmacies.

The team members had access to various stickers that they could use to alert them to issues before they handed out medicines to people. For example, interactions between medicines or the presence of a fridge line or a controlled drug that needed to be added to the bag. An audit trail was in place for dispensed medication using dispensed by and checked by signatures on labels. The pharmacy required its team members to complete a 'third check' of medicines before they were handed out to people. The process required the team members to open the bag containing dispensed medicines when people came to collect them, and to complete a visual check of them against the prescription. The pharmacist said that she was considering asking the team to carry out the check on a designated side bench to allow the process to be done without any distractions. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines. This helped the team to stop people's prescriptions from getting mixed up. The team used different coloured baskets to indicate urgency and which prescriptions required delivery. The pharmacy had a procedure in place to highlight dispensed controlled drugs, that did not require safe custody. This helped the team ensure that the medicine could not be supplied to people after the prescription had expired. Alert stickers reminding the team to check expiry dates of controlled drugs were attached to the area where dispensed medicine bags were stored. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity.

The pharmacy used alert stickers to attach to dispensed medicine bags to highlight people who were receiving high-risk medicines like warfarin. But they did not do this every time. The pharmacist was told by the team members if a bag they were about to hand out, had an alert sticker attached. And this prompted the pharmacist to give these people additional counselling, if there was a need to do so. The pharmacist also checked the INR levels for people supplied with warfarin. But it did not keep records of either the conversations or the INR records. And so, it could not use the information for future reference. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate. And they were aware of the risks. They demonstrated the advice they would

give people in a hypothetical situation. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. The team did a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. The check identified two people. These people were contacted and given the appropriate advice. The team members were aware of the warnings on the packaging of valproate and were conscious that they did not cover the warnings up when they were attaching dispensing labels.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own home. The team members completed the dispensing for these packs on a rear bench away from the retail counter. This was done to prevent any distractions, such as people waiting to be served. The team members were responsible for ordering the person's prescription. And they did this around a week in advance, so they had ample time to manage any queries. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. And they recorded details of any changes, such as dosage increases and decreases, on the master sheets. The team supplied the packs with backing sheets which contained the details of the medicines that were in the packs. And information which would help people visually identify the medicines. The team supplied patient information leaflets with the packs each month. The team members used a communications diary to relay messages to each other about the service. This helped the team maintain the service on days when some team members were absent or when locum pharmacists were working.

The pharmacy stored pharmacy only medicines behind the retail counter. The storage arrangement prevented people from self-selecting these medicines. The team checked the expiry dates of its stock every 3 months. And kept records of the activity. The team members recorded the date the pack was opened on liquid medicines. This allowed them to identify medicines that had a short-shelf life once they had been opened. And check that they were fit for purpose and safe to supply to people. The pharmacy used digital thermometers to record fridge temperatures each day. A sample of the records were looked at. And the temperatures were always within the correct range.

The team members were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software, scanners or an SOP were available to assist the team to comply with the directive. The team had not received any training on how to follow the directive. And the team members were not aware of any plans for the pharmacy to become compliant soon. The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. The alerts were stored for future reference. The pharmacy kept a record of the action taken following an alert. It also had medical waste bins and CD denaturing kits to help the team manage medicinal waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is clean and safe. And the pharmacy uses it appropriately to protect people’s confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of measuring cylinders. And tweezers were available to help the team dispense multi-compartmental compliance packs. The fridge used to store medicines was of an appropriate size. And the medicines inside were organised in an orderly manner. All the electrical equipment looked in good condition and was working. Prescription medication waiting to be collected was stored in a way that prevented people’s confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn’t seen by people. The computers were password protected to prevent any unauthorised access.

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.