General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lincoln Co-op Chemists Ltd, 90 Jasmin Road, Birchwood, LINCOLN, Lincolnshire, LN6 0QQ

Pharmacy reference: 1034285

Type of pharmacy: Community

Date of inspection: 07/08/2023

Pharmacy context

This community pharmacy is beside a small shopping centre on a housing estate to the South of Lincoln city. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It provides a range of other services including a smoking cessation counselling service and access to treatment and advice for some common health conditions through a local NHS Extended Care Service. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines.

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 works well with other healthcare organisations to enhance the learning experience for its trainee pharmacy professionals. And it actively encourages planned learning and development activities.
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 effectively identifies and manages risks associated with providing its services. It advertises how people can provide feedback, and it acts on the feedback it receives appropriately. The pharmacy generally keeps the records it needs to by law. And it keeps people's confidential information secure. Pharmacy team members understand how to respond to concerns to protect potentially vulnerable people. And they apply learning following mistakes made during the dispensing process to help reduce similar mistakes occurring.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) to support its safe and effective running. Training records showed most team members had completed learning relevant to their role. Some team members that had recently joined the team were in the process of completing this learning. They received training time and support to do this at work. Pharmacy team members had a clear understanding of their roles and responsibilities. They were confident in referring queries to the responsible pharmacist (RP) and senior team members accordingly. And those in induction and training roles were supervised well when carrying out tasks. Most team members were aware of what tasks couldn't be completed if the RP took absence from the pharmacy. A new team member explained they would seek further guidance from a senior team member before carrying out any tasks in this scenario. The pharmacy had a SOP to support the completion of final accuracy checks of medicines by accuracy checking pharmacy technicians (ACPTs). This required team members to actively check medicine history on the patient medication record (PMR) during the dispensing process. Team members referred prescriptions with changes and new medicines to the pharmacist for a clinical check to be carried out. A sample of prescriptions found this clinical check was recorded on the prescription unless the pharmacist had completed both the clinical check and final accuracy check of the medicine.

The pharmacy had processes to support its team in learning from mistakes. This learning included regularly reading correspondence sent to the pharmacy by the superintendent pharmacist's office. And sharing learning following mistakes made and identified during the dispensing process, known as near misses. A team member described how near misses would be brought to their attention and reported on an electronic template using a computer or by scanning a quick-response (QR) code on a mobile device. Team members worked to correct their own near misses when possible. Team members used a similar recording process to manage a mistake identified following the supply of a medicine to a person, known as a dispensing error. The pharmacy generally reviewed its near misses and incidents monthly to help highlight trends and implement actions to reduce risk. But records for February, March and April 2023 had not been reviewed until May 2023. And team members identified some workload pressures during this time. The team had worked hard to get back on track with regular reporting and reviews. Team members demonstrated learning and actions designed to reduce risk. For example, they had revisited learning associated with the checks required when handing out bags of assembled medicines. And the pharmacy manager was completing regular observations of the handout process to ensure this learning was embedded. Medicines identified as higher risk of being involved in a mistake following a review were moved to a 'hot shelf' in the dispensary. This prompted additional checks during the dispensing process to help minimise the risk of a mistake.

The pharmacy advertised how people could provide feedback and raise a concern. Pharmacy team members knew how to manage feedback and how to escalate a concern when required. The pharmacy had experienced a large increase in feedback and verbal abuse at the beginning of the year. This was said to be due to waiting times and turnaround times of prescriptions. The company that owned the pharmacy had put in a number of measures to help meet people's expectations and to support staff safety at work. It also ensured people visiting the pharmacy were aware of its zero-tolerance approach to abuse and aggression of its team members. It had kept these measures under review, and team members reported the number of incidents of this nature had reduced significantly. Team members engaged in mandatory learning relating to confidentiality. The pharmacy held all confidential information in the staff-only area of the premises. Confidential waste was segregated and securely disposed of. The pharmacy had procedures for safeguarding people and current contact details for safeguarding agencies were accessible. Pharmacy professionals had engaged in level two safeguarding learning to help protect vulnerable people. Other team members had engaged in some learning through discussions and e-learning. They were knowledgeable about safety initiatives designed to offer a safe space to people experiencing domestic violence. And they knew how to recognise and report safeguarding concerns.

The pharmacy had current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. But the RP record was not regularly completed in full; most entries did not have the sign-out times of the RP as required. A sample of other pharmacy records examined mostly complied with legal requirements. But details of prescribers within the private prescription record were occasionally inaccurate. The pharmacy maintained running balances in the CD register and completed regular full balance checks of physical stock against the register. It routinely checked stock balances against the register when receiving and supplying CDs. A random physical balance check of a CD conducted during the inspection complied with the running balance in the register. The team recorded patient-returned CDs in a separate section of the online register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team of people who work together well to provide its services. It reviews its skill mix and staffing levels periodically. All pharmacy team members engage in structured, ongoing and varied learning relevant to their roles. They are supervised well when working in training roles. And they have the opportunity to reflect on and discuss their learning and development needs. Pharmacy team members are supported in providing feedback and raising concerns at work. And the pharmacy uses their feedback to help improve safety.

Inspector's evidence

The pharmacy had experienced a recent change in its staffing levels and skill mix and its pharmacist manager had recently returned from a period of long term planned leave. The pharmacy team consisted of a full-time pharmacist manager, two ACPTs, a pharmacy technician, six qualified dispensers, two trainee pharmacy technicians, three trainee dispensers (two working through their induction learning), four pharmacy students and a trainee pharmacist. The pharmacy had a number of team members in training roles. It worked with other local healthcare providers to support split training placements for is trainee pharmacist and trainee pharmacy technicians. This included the pharmacy accommodating a placement for a third trainee pharmacy technician employed by a local healthcare trust. One of the ACPTs worked in a team leader role to support the manager. The team had recently focussed its efforts on addressing areas of improvement it had identified related to managing workload and continual engagement in shared learning. It was up to date with workload on date of inspection. There was some flexibility within the team to cover absences when needed.

Pharmacy team members received protected training time during working hours to support them in their learning. This included completing regular e-learning relevant to their roles. Team members engaged in a formal appraisal process to support their learning and development. The trainee pharmacist had very recently commenced their role and felt supported and able to raise any concerns they had at work. The pharmacy had a whistleblowing policy and team members knew how to raise a concern and provide feedback at work. Several newer team members commented on the positive attitude senior managers had when supporting the team. Pharmacy team members shared examples of how their feedback was used to support the safe delivery of the pharmacy's services. This included limiting the number of people in the pharmacy's public area to five and providing clear signage about the pharmacy's zero tolerance to abuse policy. Team members also had access to confidential counselling and resources to support their physical and mental health and wellbeing. Pharmacy team members were observed working well together. They generally communicated through regular conversations and formal team briefings related to workload and patient safety. The pharmacy had some targets associated with its services. The RP did not feel under undue pressure to meet targets and discussed how they applied their professional judgment when providing the pharmacy's services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and well maintained. It offers a professional image for delivering its services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and appropriately maintained. Team members knew how to report maintenance concerns and the pharmacy was subject to periodic health and safety audits. The pharmacy was generally clean and tidy. Floor spaces were free from trip and fall hazards. Lighting was bright and air conditioning helped to provide an ambient environment for delivering the pharmacy's services. Pharmacy team members had access to sinks equipped with appropriate hand washing materials. But a touch-free hand sanitiser station close to the pharmacy entrance was not working. The private consultation room was professional in appearance, and it provided a suitable environment for people to engage in private conversations with a member of the pharmacy team. It was fitted with cupboards which were used to hold a range of equipment to support the pharmacy's services. And it was appropriately secured from unauthorised access between use.

The public area was open plan with a prominent queuing system to support team members in identifying people waiting. The dispensary was a sufficient size with space managed well to support an effective workflow. Separate areas were used for labelling, assembling, and checking medicines. And the team used allocated space at the back of the dispensary to manage higher-risk tasks such as dispensing multi-compartment compliance packs and reconstituting liquid medicines. Clear workbench space was available for assembling and checking tasks. Staff toilet facilities were available in a room off the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy works well with other local healthcare providers to promote its services and ensure they are readily accessible to people. Its team members engage effectively with people to support them in taking their medicines safely. The pharmacy obtains its medicines from reputable sources. It generally stores its medicines safely and securely. And it makes regular checks to ensure they remain safe to supply to people.

Inspector's evidence

People accessed the pharmacy through a power-assisted door. The pharmacy clearly advertised its opening times and details of its services for people to see. It provided seating for people wishing to wait for their medicine or for a service. And a range of health and medicine information leaflets were available for people to take. Team members knew how to signpost people to other pharmacies or healthcare services when the pharmacy was unable to provide a service or supply a medicine. The pharmacy worked collaboratively with a local surgery by sharing details of its services. This meant quicker access to some services where people could attend the pharmacy rather than their surgery. For example, to treat some minor illnesses through the local NHS Extended Care Service, to access contraception through the NHS Pharmacy Contraception Service and to access support to help stop smoking. The pharmacy also engaged in the NHS Hypertension Case Finding service and was regularly providing blood pressure checks for people. Documents associated with the consultation services were held on a secure communication and collaboration platform. These documents included current training records, patient group directions (PGDs) and service specifications. Storing them in this way meant team members providing services could access key information easily within consultations and it reduced the burden and of handling paperwork.

A workstation to the side of the dispensary helped team members serving on the medicine counter manage queries and complete prescription claims. This setup reduced risks associated with disturbing team members concentrating on dispensing tasks. The pharmacy stored Pharmacy (P) medicines behind the medicine counter. Team members were observed following procedures when responding to requests for P medicines. They had an appropriate awareness of how to manage requests for higher-risk P medicines subject to abuse, misuse and overuse. The team identified medicines requiring counselling and monitoring checks using bright stickers attached to prescription forms. But the team did not regularly record details of these types of interventions on individual PMRs to support continual care. Team members spoken to were aware of the risks associated with dispensing valproate and the requirements of the valproate Pregnancy Prevention Programme. They had tools to support them in dispensing valproate safely. The RP had a good understanding of the counselling required when supplying valproate to a person within the at-risk group.

Audit trails supported team members in answering queries they may receive about the pharmacy's dispensing services, including the medicines the pharmacy owed to people. An audit grid on prescription forms identified who had completed individual stages of the dispensing process. Team members assembling and accuracy checking medicines also completed the 'dispensed by' and 'checked by' boxes on medicine labels. Efforts were made to ensure at least two team members were involved in the labelling and assembly stages of the dispensing process. This increased the number of checks

throughout the dispensing process to help reduce the risk of a mistake occurring. The pharmacy dispensed some medicines in multi-compartment compliance packs. Records associated with this service included a schedule to support the timely management of workload and individual patient records. Patient records included clear details of people's medicine regimens. But the team did not generally record the checks it made when confirming changes to people's medicine regimens with prescribers. The pharmacy was in the process of inviting people for suitability assessments to ensure the supply of medicines in this way was in their best interests. This review also included using an NHS medicine stability tool to assess whether a medicine remained suitable for supply in a compliance pack. The pharmacy had monitoring processes for people experiencing changes to the way their medicine was supplied due to these reviews. A sample of assembled compliance packs contained full dispensing audit trails and clear descriptions of the medicines inside the compliance packs. The pharmacy routinely supplied patient information leaflets alongside compliance packs at the beginning of each four-week cycle.

The pharmacy obtained its medicines from licensed wholesalers and stored them tidily. It held most medicines in their original packaging. A small number of medicines were found in stock which were not kept in their original packaging and without supportive information available such as expiry dates. This was discussed with the team and the medicines were disposed of. Efforts had been made to separate some higher-risk medicines on dispensary shelves. But methotrexate 2.5mg and 10mg were stored together in a basket. The RP explained the 10mg tablets should be stored in a clear bag within the basket. They acted to do this and said they would remind the team of this requirement. The pharmacy kept CDs securely, with segregated areas for storing date-expired CDs and CDs people had returned. The pharmacy had three fridges with good storage arrangements to support easy retrieval of assembled medicines. The pharmacy kept temperature records for its fridges, and these showed they generally operated within the appropriate temperature range. But team members did not always annotate the record to show any action they had taken when a fridge temperature fluctuated outside of the appropriate range. The team recorded activities associated with date checking. And it highlighted short-dated medicines with stickers. Random checks of dispensary stock found one out-of-date liquid medicine. This was appropriately annotated with its date of opening to support checks at the point of dispensing. The RP acted to dispose of the medicine appropriately. The pharmacy had appropriate medical waste bins to support the safe disposal of medicine waste. And it stored these securely. It received medicine alerts electronically and it kept an audit trail of the action it took in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has appropriate and well-maintained equipment and facilities for providing its services. Its team members use its equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members accessed hardcopy and electronic reference resources. They also accessed the company's intranet and the internet to assist them with answering queries and obtaining information. The pharmacy protected its computers from unauthorised access by using passwords and NHS smart cards. It stored bags of assembled medicines safely in a retrieval area to the side of the dispensary. Pharmacy team members used cordless telephone handsets when speaking to people over the telephone. This allowed them to move towards the back of the dispensary or into the consultation room to protect people's privacy.

The pharmacy team used a range of appropriate equipment to support it in delivering the pharmacy's services. For example, crown-stamped measuring cylinders for measuring liquid medicine with separate measures identified for use only with a higher-risk liquid medicine. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. For example, the pharmacy's blood pressure monitors were on the list of monitors validated for use by the British and Irish Hypertension Society.

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.