General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lincoln Co-op Chemists Ltd, 7 High Street, SPILSBY, Lincolnshire, PE23 5JJ

Pharmacy reference: 1034323

Type of pharmacy: Community

Date of inspection: 14/08/2019

Pharmacy context

This is a community pharmacy in a small rural market town in Lincolnshire. The pharmacy sells over-the-counter medicines and it dispenses NHS and private prescriptions. The pharmacy offers advice on the management of minor illnesses and long-term conditions. And it provides some free services to encourage people in maintaining a healthy lifestyle. The pharmacy supplies medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers medicines to people's homes.

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	1.8	Good practice	Pharmacy team members have a clear understanding of how to safeguard the safety and wellbeing of vulnerable people. And the pharmacy has support for staff who raise these types of concerns.
2. Staff	Standards met	2.5	Good practice	The pharmacy encourages its team members to provide feedback. It uses this feedback to inform the safe management of its services. And it shares improvements to its working practices with other pharmacy teams.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	Pharmacy team members have a genuine passion for encouraging people to improve their health and wellbeing. And they have reached out to the community to promote the role of community pharmacy. And to raise awareness of medicine safety issues
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages the risks associated with its services. It advertises how people can provide feedback about its services. And it responds appropriately to the feedback it receives. The pharmacy keeps people's private information secure. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they engage in some shared learning processes to help reduce identified risks. Pharmacy team members have a clear understanding of how to safeguard the safety and wellbeing of vulnerable people. And the pharmacy has support for staff who raise these types of concerns. The pharmacy generally keeps all records it must by law. But some gaps in these records occasionally result in incomplete audit trails.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). These included responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The SOPs were last reviewed in April 2019, ahead of their scheduled two-year review date. And the review had considered changes in dispensing processes following the introduction of the Falsified Medicines Directive (FMD). The review included a published list of significant changes to SOPs. Pharmacy team members were working their way through reading and signing the updated SOPs. There had been some delay in pharmacy team members completing this process due to staffing pressures on the team. But the responsible pharmacist (RP) confirmed this issue was now rectified. The SOPs set out the roles and responsibilities of staff. A member of the team explained what tasks could and couldn't be completed if the RP took absence from the premises. The RP had reviewed the SOP in place to support the role of the accuracy checking technician (ACT) and had highlighted and written additional information to underpin the safety processes in place for managing these checks.

NHS item numbers had increased by approximately 25% since the last inspection in 2015. The team managed the increased workload with good organisation in the dispensary. Work benches were clear of clutter and workload was effectively managed. Labelling, assembly and accuracy checks took place in separate areas of the dispensary. Acute work was managed at the front of the dispensary and a bench to the side of the dispensary was used to process much of the managed workload. Tasks associated with the multi-compartment compliance pack service were completed at the back of the dispensary. This provided a relatively distraction free environment for assembling packs.

Pharmacy team members took ownership of their mistakes by discussing them with the pharmacist or accuracy checking technician at the time they occurred. A near-miss error log was used to record mistakes made during the dispensing process. There were some gaps in near-miss reporting during periods where staff levels were lower than normal. But the team had recently been engaging well with reporting processes. The pharmacy reported dispensing incidents to its superintendent pharmacist through an electronic reporting programme. It recorded details of the incidents and initial actions it had taken to correct the error. But pharmacy team members did not routinely go back into reports to review any further actions required following the Superintendent's review of the incident.

A pharmacy technician completed a patient safety review and the RP had clinical input into this review. The frequency of these reviews varied between quarterly and monthly. The team had completed them

monthly for the last few months. Near-misses, incidents and intervention rates were documented during the review along with brief information relating to risk reduction strategies. The review was shared between team members to help inform learning. Pharmacy team members identified how they used empty white boxes on dispensary shelves to split different strengths and formulations of the same medicines or similar looking and sounding medicines to help reduce the risk of picking error.

The pharmacy had a complaints procedure in place. And it provided details of how people could leave feedback or raise a concern about the pharmacy through both its practice leaflet and a notice displayed in the public area. A member of the team explained how she would manage a complaint and understood how to escalate concerns if required. Pharmacy team members explained how they had managed a recent concern. And had taken steps to document the concern. The pharmacy also promoted feedback through their annual 'Community Pharmacy Patient Questionnaire'. It published the results of this questionnaire for people using the pharmacy to see.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice contained the correct details of the RP on duty. Entries in the responsible pharmacist record generally complied with legal requirements, one missed sign-out time was seen in the sample of the register examined. The sample of the controlled drug (CD) register examined was compliant with legal requirements. The pharmacy maintained running balances in the register. And two members of the team checked these balances when receiving and dispensing CDs. But regular full balance checks against physical stock had lapsed in recent months. This meant the pharmacy may not identify a balance discrepancy of a CD if that CD was infrequently dispensed. Physical balance checks of several morphine preparations complied with the balances in the register. The pharmacy maintained a CD destruction register for patient returned medicines. And the team entered returns in the register on the date of receipt. The pharmacy kept records for private prescriptions and emergency supplies within its prescription only medicine (POM) register. There were some omissions in private prescription entries. For example, the address of the prescriber was not always recorded. Some details of emergency supplies had been recorded using dispensing labels. The RP had recognised this was not good practice and had asked team members to ensure other pharmacists recorded these entries in indelible ink. The pharmacy retained certificates of conformity for unlicensed medicines. But some recent certificates had been filed without details of who the medicine had been supplied to. A discussion took place about the need to retain this information on the pharmacy's copy of this certificate.

The pharmacy displayed a privacy notice and all pharmacy team members had completed mandatory information governance training. This included updated e-learning following the introduction of the General Data Protection Regulation (GDPR). They demonstrated how their working processes kept people's information safe and secure. And all person identifiable information was stored in staff only areas of the pharmacy. The pharmacy had submitted its annual NHS information governance toolkit. It disposed of confidential waste through secure Shred-it bins which were collected periodically.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. Pharmacy team members had completed e-learning on the subject and all pharmacy professionals had completed level two safeguarding training. Pharmacy team members demonstrated a sound understanding of how they would recognise and report safeguarding concerns. And they regularly shared information with each other when minor concerns arose. Different members of the team could explain the steps the pharmacy had taken to safeguard potentially vulnerable individuals. The pharmacy had support systems in place to ensure staff who reported concerns received appropriate support when required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services safely. It encourages its team members to provide feedback. It uses this feedback to inform the safe management of its services. And it shares improvements to its working practices with other pharmacy teams. The pharmacy supports the learning needs of its team members through ongoing training and structured feedback. Pharmacy team members share learning by engaging in regular conversations relating to risk management and safety.

Inspector's evidence

On duty at the time of inspection was the RP (pharmacy manager), an ACT, two pharmacy technicians, a level two qualified dispenser and a medicine counter assistant. The pharmacy also employed another two part-time medicine counter assistants, another part-time dispenser and a delivery driver. Pharmacy team members expressed they had had a difficult year due to three members of the team leaving. Two members of the team had been replaced with qualified members of staff, including a pharmacy technician. This had helped to retain the pharmacy's skill mix. A new ACT/Team leader was due to join the team within the next week. The ACT supporting the pharmacy at the time of inspection was based at a different branch. He was providing part-time ACT cover prior to the new ACT commencing his role.

The pharmacy team members were observed greeting many people by name and engaged in conversation with people about their health and wellbeing. Dispensing workload at the time of inspection was up to date. There was a strong sense of team spirit amongst staff with them working hard to support each other. The pharmacy had a task rota to help rotate tasks amongst the team. This helped to ensure key tasks such as checking emails and actioning drug alerts was kept up to date. It also meant that all dispensary staff were competent in undertaking different aspects of their roles, such as managing the assembly of multi-compartmental compliance packs.

Pharmacy team members engaged in regular learning. They did not receive protected learning time but confirmed that time would be made available when training required completion. For example, staff had recently completed Children's oral health training during working hours. The pharmacy had a structured appraisal process. The manager met with each member of the team annually to review their performance and development and discuss both personal and business objectives. The pharmacy participated in a 'branch of the year' competition. This encouraged engagement with services and promoted good customer service skills. The RP explained this approach to meeting targets was flexible and explained processes she had developed to support service delivery. For example, a New Medicines Service (NMS) calendar was located at the pharmacist's checking bench to remind pharmacists of the need to complete follow up consultations with people enrolled on the service.

There was an agenda on the dispensary wall ready for an upcoming team meeting. And members of the team were invited to add topics for discussion. Pharmacy team members explained it had been some time since the last structured team meeting due to the staffing issues experienced. Priority had been on completing daily tasks and keeping up to date with dispensing workload during this time. And feedback had been shared through short informal briefings and daily discussions.

The pharmacy had a whistleblowing policy in place. And pharmacy team members demonstrated through discussion a clear understanding of how to raise a concern or provide feedback. They expressed that they felt supported at work and were confident in providing feedback. The RP explained the area manager had been particularly supportive throughout the recent staffing situation. The pharmacy promoted feedback and shared learning. For example, it advertised details of the company's 'Together' programme which encouraged feedback and ideas. The RP explained feedback was shared between other pharmacy's through a group sharing system. For example, working processes associated with FMD had been shared in this way. A new member of the team had shared ideas on how to improve stock management in the pharmacy. And the team had reorganised the dispensary shelves because of this feedback. The RP had created a CD validity calculator, based on a calendar to efficiently work out 28 days from the date of prescribing. This had helped improve checks associated with CD prescriptions. And another pharmacist had taken the idea and shared it in a different branch.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It provides a professional environment for the delivery of healthcare services. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was clean and secure. It was in an old building, the ground-floor level had been modernised and provided a professional image to people accessing the pharmacy. Pharmacy team members reported maintenance concerns to a designated support team. They had raised several concerns about a small leak at the front of the store when it rained heavily. The maintenance team had addressed the issue on several occasions. The manager confirmed the issue was being monitored. And it was not seen to pose a health and safety concern.

The dispensary was air-conditioned, and heating was in place. Lighting was bright. Work areas were clutter free and floor spaces were clear of obstruction. The pharmacy had designated hand washing sinks, including a sink in the consultation room. Antibacterial soap and paper towels were available close to these sinks. The pharmacy team primarily used the dispensary sink to reconstitute liquid medicines.

The public area of the pharmacy was open plan and led to the medicine counter. The pharmacist had good supervision of the area from her checking station. The pharmacy had a consultation room located to the side of the counter. The public door leading into the room remained locked between use. This helped prevent unauthorised access into the room. The room was bright and clean. It was sign-posted and offered a suitable space for holding confidential conversations with people. Pharmacy team members were observed using the room with people accessing some of the pharmacy's services.

The dispensary was a sufficient size for the activities taking place. And pharmacy team members managed the space available well. For example, both the pharmacist and ACT had protected checking areas. There was access to a staff toilet off the dispensary and a small store room to the side of the medicine counter. The first-floor level of the pharmacy provided further staff facilities and storage space for holding dispensary sundries.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services easily accessible to people. Its team members have a genuine passion for encouraging people to improve their health and wellbeing. They have reached out to the community to promote the role of community pharmacy. And to raise awareness of medicine safety issues. The pharmacy has records and systems in place to make sure people get the right medicines at the right time. It obtains its medicines from reputable sources. And it generally manages them appropriately to help make sure they are safe to use.

Inspector's evidence

The pharmacy was accessed through a simple push/pull door up a very small ramp from street level. The pharmacy clearly advertised details of its opening times and services. Its window displays were professional and engaging. For example, one display was promoting an NHS medicine waste reduction scheme in an innovative way. It displayed empty containers of returned medicines and invited people to guess the cost of the medicines by entering a competition to win an electric toothbrush. Pharmacy team members used their own local knowledge and information available on the internet to help signpost people to other healthcare organisations when required.

The pharmacy was committed to engaging people in health services designed to support their health and wellbeing. It did this through offering people lifestyle and healthy living advice when visiting the pharmacy. And its team members supported the company's 'Community Health Pod' by attending countywide shows and offering people healthy living checks. The RP reflected on how engaging the health pod was with people who didn't regularly visit pharmacies. For example, people with slightly elevated blood pressure readings were encouraged to attend their local pharmacy for free checks to help monitor and refer on to GP services if necessary.

The pharmacy had made some significant referrals through its in-house health check services. For example, a person had been referred for an urgent GP review and was immediately started on treatment for hypertension following a health check. The pharmacy's weight management programme was popular. The programme focussed on providing lifestyle and diet advice, assisted by free weekly weigh-ins. A number of people had successfully lost weight through the service. And some of these had gone on to promote their success in the company's community magazine.

The RP explained how engaging people in services and supporting them with their health needs helped to establish good relationships and promote the role of community pharmacy. The RP demonstrated how she completed an assessment of people requiring additional assistance with their medicines, such as those who forgot to take their medicines. The assessment involved identifying the issue and considering options and alternative ways to help people take their medicines. The RP explained that multi-compartmental compliance packs were not the best option for all people. And examples of how the team had assisted people in taking their medicines following the assessments was discussed. For example, encouraging people to adapt their daily routine to accommodate taking their medicines and by using diary reminders. The pharmacy was promoting a text messaging service. And pharmacy team members explained how effective it was in reminding people that their prescriptions were ready for collection.

The pharmacy team was aware of the risks associated with the supply of high-risk medicines. They demonstrated how they identified prescriptions for medicines such as warfarin, methotrexate, lithium and valproate. The pharmacy recorded details of monitoring checks for warfarin on people's medication records. Pharmacy team members were knowledgeable about the requirements of the valproate pregnancy prevention programme (PPP) and warning cards were readily available to issue to people in the high-risk group. But these were not issued every time a prescription for valproate was dispensed to people in this group.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. And these prescriptions were held on a separate shelf in the dispensary. This prompted regular checks of medicines owed to people and helped improve efficiency when the medicine was received into stock. The pharmacy kept records of the medicines it delivered. People generally signed for their deliveries. But some deliveries were signed by the driver on the person's behalf. Pharmacy team members explained this would be on occasions when the person receiving the medicine could not sign the record themselves. For example, if they used a walking frame to get to the door and asking them to sign would increase the risk of a fall.

The pharmacy used a planner to manage work associated with the multi-compartmental compliance pack service. The team followed processes to monitor the receipt of prescriptions and applied checks of the prescriptions against individual profile sheets. This allowed the team to identify and query changes and missing prescriptions. Pharmacy team members recorded details of changes within profile sheets. They generally completed an audit sheet to identify who had labelled, assembled and checked each pack. Some minor omissions in these records was seen. But assembled packs did contain full dispensing audit trails and they contained a description of the medicines inside to help people identify their medicines. The pharmacy supplied patient information leaflets at the beginning of each four-week cycle of packs.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members demonstrated how they complied with FMD. The pharmacy had two scanning stations set up and its team members were observed routinely decommissioning medicines during the dispensing process. They clearly marked split packs of medicines that had been decommissioned. Pharmacy team members had identified some teething issues with the system. For example, the system appeared to allow the same packet of medicine to be decommissioned multiple times. The pharmacy had systems in place to report this feedback and pharmacy team members had received appropriate training and support prior to the system being implemented.

The pharmacy stored Pharmacy medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. The pharmacy stored medicines in the dispensary in an organised manner. Pharmacy team members recorded medicines with shorted expiry dates and marked these. But they had not recorded details of how often they were carrying out date checking tasks. Several medicines were found to be out of date during random checks of dispensary stock. But pharmacy team members did routinely check expiry dates during the dispensing process, this reduced the risk of these medicines being supplied in error. The team annotated details of opening dates on bottles of liquid medicines.

The pharmacy had an appropriate supply of medicine waste bins, sharps waste bins and CD denaturing kits available. It was notified of medicine and medical device alerts via email. This prompted team

members to log onto an electronic reporting system to obtain details of the alert. They submitted electronic notification that the alert had been checked.

The pharmacy held CDs in secure cabinets. Medicine storage inside the cabinets was orderly. There was designated space for storing patient returns, and out-of-date CDs. Assembled CDs were held in clear bags and clearly marked. Pharmacy team members could explain the validity requirements of a CD prescription and demonstrated how CD prescriptions were highlighted to prompt additional checks during the dispensing process. The pharmacy's fridge was clean and stock inside was stored in an organised manner. The pharmacy used clear bags to store assembled cold chain medicines. This prompted additional checks of high-risk medicines such as insulin prior to hand-out. Fridge temperature records confirmed that the fridge was operating between two and eight degrees Celsius as required.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the equipment and facilities it needs for providing its services. It regularly monitors and replaces its equipment to help provide assurance that it is in safe working order. And pharmacy team members manage and use equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had some written reference resources available. And the RP used smartphone applications and the internet to access the most up-to-date clinical reference guides, such as the BNF. The pharmacy's computer system was password protected and information on computer monitors was protected from unauthorised view through the layout of the premises. Pharmacy team members on duty had working NHS smart cards. The pharmacy stored assembled bags of medicines on allocated shelving to the side of the dispensary. This protected people's private information against unauthorised view. Pharmacy team members used cordless telephone handsets when speaking to people over the telephone. This meant they could move out of ear-shot of the public area when having confidential conversations with people over the telephone.

Clean, crown stamped measuring cylinders were in place for measuring liquid medicines, including separate cylinders for use solely with methadone. The pharmacy had clean counting equipment for tablets and capsules. A separate triangle for use when counting cytotoxic medicines was stored in a protective bag to prevent any risk of cross-contamination with other equipment. Pharmacy team members had access to safety equipment when dispensing medicines such as disposable gloves. The pharmacy regularly replaced equipment for its health check services. For example, its blood pressure machine and blood glucose machine. Other equipment to support health checks, such as single-use safety lancets and sharps bins were readily available and stored safely. The pharmacy's electrical equipment had been subject to safety checks in June 2019.

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.