General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lincoln Co-op Chemists Ltd, 28 High Street, Metheringham, LINCOLN, Lincolnshire, LN4 3EA

Pharmacy reference: 1087836

Type of pharmacy: Community

Date of inspection: 27/02/2024

Pharmacy context

The pharmacy is co-located with the village Post Office in Metheringham, a rural village in Lincolnshire. Its main services are dispensing prescriptions and selling over-the-counter medicines. It provides a range of consultation services to support people's health needs, including a smoking cessation service and supporting people with minor illnesses. It also 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	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 effectively identifies and managed the risks for the services it provides. It responds to feedback appropriately and generally it keeps the records required by law in good order. Pharmacy team members manage people's confidential information with care. They know how to recognise, and report concerns to help keep vulnerable people safe from harm. And they act openly and honestly by recording and discussing the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to support its safe and effective running. A statement provided by the superintendent pharmacist (SI) provided details of the latest review of SOPs in April 2023. Pharmacy team members accessed the SOPs electronically and demonstrated how they followed them when completing tasks. For example, by annotating prescriptions during the dispensing process to support an accuracy checking pharmacy technician (ACPT) in undertaking the final accuracy check of a medicine. But not all team members had not completed some training records for all the SOPs relevant to their role. The responsible pharmacist (RP) on duty was a locum pharmacist, they had been provided with access to the pharmacy's SOPs to support them in their role.

The pharmacy had processes for managing mistakes identified during the dispensing process, known as near misses. Following a near miss, team members checked their work again and corrected the mistake. Team members felt that consistency in reporting near misses had improved in recent months following some learning about the importance of reporting as well as correcting mistakes. Near miss records identified contributory factors and team members showed examples of actions they had taken to reduce risk. For example, separating medicines with similar names within the dispensary. The pharmacy held some medicines in baskets on the dispensary shelves to highlight the need to pay extra attention when storing and picking these medicines. The pharmacy had an incident reporting procedure in the event a mistake was identified following the supply of a medicine to a person, known as a dispensing incident. A team member reflected on a recent incident, they had identified the root cause and discussed the learnings completed to reduce the risk of a similar mistake occurring. The team shared feedback about mistakes through conversations. But it did not document these discussions or formally review the actions it took to reduce risk. This meant there may be some missed opportunities to share learning and to measure the effectiveness of any actions taken.

The pharmacy advertised how people could provide feedback or raise a concern about the pharmacy. It also displayed notices asking people to treat its team members with respect. And informing people of the company's zero tolerance approach to abuse and violence directed at its team members. The pharmacy team responded to the feedback it received appropriately. For example, a team member explained how they had adapted the way they served people at the medicine counter following some feedback about customer service. The pharmacy displayed helpful information to manage people's expectations about the turnaround time of prescriptions from ordering to collection, and it encouraged people to sign-up to a text message alert system to inform them when their medication was ready to collect.

The pharmacy had current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. And the RP record was generally completed in full, one recent record did not have the sign-out time of the RP. A sample of other pharmacy records mostly complied with legal and regulatory requirements. The team recorded all legally required information when dispensing private prescriptions. But individual records on the patient medication record (PMR) system needed to be accessed to view full information of the prescription such as details of the prescriber and prescription date. The pharmacy had retained some private prescriptions for schedule 3 CDs rather than submitting them to the NHS after dispensing as required. This was brought to the team leaders' attention. The pharmacy held its CD register electronically. It maintained running balances and these balances were checked upon the supply of a CD. Regular full balance checks of all physical stock against the CD register took place. Random physical balance checks of CDs conducted during the inspection complied with the running balances in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

The pharmacy's SOPs included confidentiality and data protection requirements. And all team members engaged in mandatory information governance learning. The pharmacy held all personal identifiable information in the staff-only area of the premises and confidential waste was appropriately separated and securely disposed of. The pharmacy had safeguarding procedures available to its team members to refer to. Team members engaged in safeguarding learning to support them in identifying and reporting these types of concerns. This learning had included information about safety initiatives designed to offer a safe space to people experiencing domestic violence. The pharmacy had processes to monitor the collection of medicines prescribed weekly to people. This helped to ensure people were collecting these medicines as required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members and has considered the skill mix of its team to support it in safely managing its services. Pharmacy team members engage in regular learning relevant to their role. And they understand the importance of engaging in processes designed to support their ongoing learning and development. Pharmacy team members work together well and are supportive of each other. They are confident in providing feedback and they know how to raise a concern at work.

Inspector's evidence

The RP on duty was working their first shift at the pharmacy. They were working alongside the pharmacy's team leader who was an ACPT, another ACPT who was a member of the company's wider relief team, a qualified dispenser, a qualified medicine counter assistant (MCA) and an apprentice. The pharmacy also employed a pharmacist manager, another ACPT, another qualified dispenser and two trainees. The pharmacy used a rota to help identify any need for flexible working within the current team and to help plan requests for additional support from the relief team. Pharmacy team members were observed working well together. A team member explained that the team had sought extra support the week prior to the inspection ahead of the manager's planned leave. The pharmacy team used a diary to book appointments for services such as the NHS blood pressure check service. This helped the team plan ahead and ensure it was safely managing all of the services it provided.

Two team members were enrolled on GPhC accredited dispensing courses relevant to their role. Another team member had recently commenced their role and was undertaking learning as part of their induction. Team members enrolled on accredited courses received protected training time to support them in their learning. The apprentice felt confident to ask questions and was supported in their role. They knew how to provide feedback about their training if needed. All team members engaged in continual learning to support them in delivering the pharmacy's services. This included mandatory e-learning and specific learning to support consultation services. For example, a team member had recently attended a face-to-face learning update hosted by the smoking cessation provider. A team member explained they had recently had their annual appraisal and felt able to feedback as part of the appraisal process. The pharmacy had some targets for its services. Team members were positive when discussing these targets and pharmacy professionals clearly indicated they were supported in applying their professional judgement when providing pharmacy services.

Pharmacy team members communicated through frequent, informal conversations. A team member was available to check emails twice daily and shared details of emails with the team to help them keep up to date with information received in this way. The pharmacy had a whistle blowing policy and its team members understood how they could raise and escalate a concern at work. And the pharmacy responded to the feedback it received from its team members appropriately. For example, the team had been supplied with a desk to support it in creating a quiet area for its team members undertaking training at work. This allowed the consultation room to remain accessible to people attending the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and secure. They provide a professional environment for delivering healthcare services. People using the pharmacy are able to speak to a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and appropriately maintained. An engineer attended the pharmacy during the inspection to investigate a recently reported issue with a radiator. The pharmacy was clean and organised. Air conditioning provided an ambient temperature for delivering pharmacy services and lighting was bright throughout the premises. Pharmacy team members had access to sinks equipped with antibacterial hand wash and paper towels. A door at the back of the dispensary led to an area of the premises shared with the Post Office. This space provided access to staff facilities and a storeroom accessible only to pharmacy staff. An area of the storeroom was used as a staff break and study area.

The public area was open plan with seating provided for people. The pharmacy had a good size consultation room. This was clearly advertised, and it was professional in appearance. The room contained a sink for hand washing and equipment to support the pharmacy's consultation services. The team used space in the dispensary effectively to manage acute and planned workload. Some use of space was flexible depending on the skill mix of staff on duty. For example, the team created two separate workstations for its ACPTs when were on shift together. The RP had suitable protected space on a workbench at the front of the dispensary. And the team used protected space at the back of the dispensary when completing higher-risk tasks such as assembling medicines in multi-compartment compliance pack.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy ensures its services are easily accessible for people. And it effectively informs people of both its own services and of the local services available to support their health and wellbeing. The pharmacy obtains its medicines from reputable sources. And it generally stores its medicines safely and securely. Pharmacy team members provide relevant information to people to help them take their medicines safely.

Inspector's evidence

People accessed the pharmacy through doors from street level. The pharmacy advertised its opening times and details of its services for people to see. Team members had a good awareness of local support groups to help people who may feel lonely or who needed extra support. And they provided examples of how they signposted people to a local community hub. The team also understood the importance of talking to carers to ensure they knew about the support available to them. The pharmacy had a wide range of informative leaflets available for people to take, these included about living with long term conditions and steps people could take to improve their overall health and wellbeing. It had a leaflet asking people to bring any specific communication needs to the attention of one of its team members. A team member explained how they would tailor their communication to the person they were speaking to. The pharmacy stored Pharmacy (P) medicines behind the medicine counter. The RP had appropriate supervision over the medicine counter and public area.

The pharmacy provided a range of consultation services, including consultations to support people accessing treatment and advice for some minor illnesses. Pharmacists providing these services had access to service specifications, procedures, and current Patient Group Directions (PGDs) to help them provide the service safely. The RP on duty discussed the learning they had completed in order to undertake consultation services. A dispenser provided the smoking cessation service. The team member demonstrated how they managed this service and checked-in regularly with people to support them in their quit attempt. The pharmacy team worked together well with the local GP surgery for the benefit of people using healthcare services in the village. It did this through holding meetings with the surgery management team and sharing information about the services the pharmacy provided. And they worked together to promote key messages to people using their services.

Pharmacy team members understood the requirements of the valproate Pregnancy Prevention Programme (PPP), including the need to supply valproate in original containers. The RP explained the checks they would make when dispensing a prescription for valproate. A team member discussed the range of audits the pharmacy engaged in to ensure it identified and supported people using medicines such as valproate, anticoagulants, and asthma inhalers. The pharmacy had a process for flagging prescriptions to inform team members of the need to refer to a pharmacist for further counselling. But team members did not regularly take the opportunity to record these types of verbal interventions on people’s medication records to support continual care.

The pharmacy team used baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. It had robust processes for identifying CDs and medicines requiring specific storage conditions, such as those requiring refrigerated storage.

This helped to ensure medicines were stored safely in the right environment, and it prompted additional checks of assembled medicines when handing them out. Team members took ownership of their work by signing their initials within the 'dispensed by' and 'checked by' boxes on medicine labels. And they provided relevant safety information when supplying medicines, such as patient information leaflets. The team also provided details of the batch number and expiry date of a medicine when not supplying it in its original packaging. The pharmacy had an effective system for managing owed medicines. Team members made regular checks to establish stock availability. The pharmacy supplied medicines in multi-compartment compliance packs to a small number of people. It engaged people in an assessment prior to providing medicines in this way to help ensure this was the most effective way of making the supply. The pharmacy team used a work schedule and individual patient records to support it in providing the service safely. It normally crossed out and annotated individual records with dates of changes to medicine regimens. But team members did not regularly document the checks it made to support it in applying changes. This meant it might be more difficult for team members to answer any queries related to the changes made. The pharmacy delivered some multi-compartment compliance packs to people through the company's centralised delivery service. It kept an audit trail of the medicines it sent through this service. A sample of compliance packs examined were labelled clearly with handwritten descriptions of the medicines inside the compliance pack provided.

The pharmacy obtained its medicines from licensed wholesalers, and it stored them tidily and within their original packaging. The team recorded medicines with shortened expiry dates as part of its rotational date checks. But the team did not always record how often it was date checking its medicines. And a check of equipment held in the consultation room found an expired adrenaline auto-pen, other adrenaline ampoules held in the room expired within the next few days. The checks also found some expired equipment for supporting cholesterol and diabetes checks. A team member explained the pharmacy had recently received this testing equipment in preparation for a new service and agreed they would report this matter to their supplier. A random check of dispensary stock found no out-of-date medicines. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy kept CDs securely in cabinets, there was designated space within the cabinets for holding assembled medicines, date-expired and patient-returned CDs. The pharmacy's medicine fridges were an appropriate size for the medicines they held. The team monitored the operating range of the fridges twice daily and recorded the steps they took if the temperature went outside of the required range. The pharmacy had appropriate medical waste receptacles to support the safe disposal of medicine waste. It received medicine alerts electronically and documented the actions it took in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for providing its services. It monitors it equipment to ensure it remains in safe working order. And pharmacy team members use equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to current reference resources and to the internet to support them in obtaining information and providing advice to people. They accessed password-protected computers and used NHS smart cards to access people's medication records. The layout of the premises protected information on the pharmacy's computer monitors from unauthorised view. The pharmacy stored bags of assembled medicines on shelving to the side of the dispensary. This arrangement effectively protected people's personal information. The pharmacy had a range of clean equipment for counting and measuring medicines. And it clearly identified separate equipment for use when counting and measuring higher-risk medicines to mitigate the risk of cross contamination. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. The pharmacy had defined processes for maintaining its equipment to help ensure it remained safe to use and fit for purpose. And team members cleaned equipment appropriately between use.

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.