General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lincoln Co-Operative Chemists Ltd, Boston Road, Kirton, BOSTON, Lincolnshire, PE20 1DS

Pharmacy reference: 1090702

Type of pharmacy: Community

Date of inspection: 03/09/2024

Pharmacy context

This pharmacy is in a village close to the town of Boston in Lincolnshire. Its main services include dispensing prescriptions and selling over-the-counter medicines. The pharmacy completes assessments for people who are struggling to remember to take their medicines. And as a result it adjusts the way it provides some medicines to people including making supplies of medicines in multi-compartment compliance packs. The pharmacy provides a range of NHS consultation services including Pharmacy First, the New Medicine Service (NMS), contraception, smoking cessation, and blood pressure checks.

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 supports its team members to develop in their roles. They use the knowledge they gain from regular learning to support them in delivering the pharmacy's services safely and effectively.
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 the risks for the services it provides. It keeps its records as required by law and it responds to concerns appropriately. Pharmacy team members understand the importance of keeping people's confidential information secure. They work together with other healthcare providers to help keep vulnerable people safe from harm. And they engage in regular shared learning opportunities designed to reduce risk following 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. These had been reviewed in 2023 by the superintendent pharmacist (SI). Additional SOPs had been implemented since 2023 to support team members in completing new services and additional checks where required. For example, there had been an update to the SOP for dispensing valproate following a legal update to the requirements of the pregnancy prevention programme (PPP) in October 2023. A sample of team members demonstrated their learning records confirming they had read and understood the SOPs. A team member discussed what tasks could not be completed if the responsible pharmacist (RP) took absence from the premises. The pharmacy employed some pharmacy technicians working in accuracy checking roles (ACPTs). ACPTs checked repeat medicines only and demonstrated how the dispensing process identified any changes to people's medicine regimens which would prompt a referral to the RP for a clinical check. They had immediate access to the patient medication record (PMR) system when undertaking accuracy checking tasks.

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 generally reported their mistakes following feedback from the accuracy checker. But during a recent period of heightened staffing pressures near miss reporting rates had reduced, reflecting the pressures the team were under. The pharmacy had a clear process for reporting mistakes identified following the supply of a medicine to a person, known as a dispensing incident. Incident reporting included identifying the root cause of the mistake and identified actions required to reduce risk. A check of some of these recorded actions found the team had implemented these. The pharmacy team engaged in a regular patient safety review process which involved analysing the mistakes reported. Team members were aware of recent actions implemented to reduce risk and they demonstrated these, such as separating medicines with similar sounding names.

The pharmacy had information available to inform people how they could provide feedback or raise a concern about the pharmacy. But some information on the notice was outdated and the notice was not clearly visible to people visiting the pharmacy as it was lent against a wall behind the medicine counter along with other notices. Pharmacy team members reported some barriers to escalating a recent concern due to uncertainty on where to find contact information to support them in doing this. This had been resolved in a timely manner and team members had refreshed their understanding of the escalation process following the event. Team members provided examples of how they responded to feedback and worked to resolve concerns locally whenever possible.

The pharmacy had current professional indemnity insurance. The RP notice on display contained the correct details of the RP on duty. A sample of the RP record, private prescription register and unlicensed medicine records examined found records to be made in line with legal and regulatory requirements. The pharmacy held its controlled drug (CD) register electronically. It maintained running balances in the register and team members checked these balances upon receipt and 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 part of the register at the point of receipt.

Pharmacy team members engaged in a range of mandatory training including information governance and safeguarding learning. The pharmacy complied with NHS requirements to review its data security on a regular basis and its SOPs clearly set out how confidential information should be managed. A team member provided an example of how they worked to keep people's confidential information safe. The pharmacy stored all personal identifiable information in staff-only areas of the premises. And it segregated and disposed of its confidential waste securely. Team member had access to helpful information to support them in identifying and reporting concerns about potentially vulnerable people. They understood how to recognise and escalate any concerns they had. And they demonstrated how they worked with the local GP surgery team to help keep vulnerable people safe from harm. This included monitoring the collection of medicines and dispensing smaller quantities of medicines more frequently to people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs team members with appropriate knowledge and skills to support the delivery of its services. Pharmacy team members work enthusiastically in their roles, and they support each other well. They clearly show how they apply the knowledge and skills they gain through continual learning to support them in delivering the pharmacy's services safely. Pharmacy team members take regular opportunities to share their learning with each other. And they understand how to raise and escalate a concern at work.

Inspector's evidence

The RP was the pharmacy manager. They were supported by two ACPTs, a pharmacy technician, three dispensers and a pharmacy student. A pre-registration pharmacy technician joined the team towards the end of the inspection. The pharmacy also employed another ACPT who was the team leader, another pharmacy technician, and another dispenser. Team members worked flexibly during periods of planned and unplanned leave. But team members explained that the team had experienced heightened pressures over the summer due to both planned and unplanned leave. Support had been unavailable from the relief team and other pharmacies during this time due to the summer holiday season. The team had identified areas of priority during this time, it was currently bringing some tasks such as stock management checks up to date now staffing levels had stabilised. The pharmacy manager explained that a new team member had been appointed and part of their role involved providing relief cover across the area. And they were aware that new team members would be working in this way to support flexible working across the company's pharmacies.

Pharmacy team members were committed to completing regular learning to support them in their roles. Team members demonstrated how they used the knowledge they acquired through learning when providing pharmacy services. For example, team members providing the smoking cessation service attended regular updates and had received guidance on how to manage queries about the use of vaping products. Team members reported receiving protected time to complete learning at work and they were supported in identifying development opportunities through a structured appraisal process. A trainee team member took the opportunity to return from their study time earlier than normal in order to be present and use the inspection process as a learning opportunity to support their understanding of the GPhC's premises standards. The team member felt confident in addressing any concerns they had with their training, and they felt supported in their role.

The pharmacy had some targets for its services. Team members discussed focussing on providing positive experiences for people. Team members understood the benefits for people of the pharmacy services they provided. And registered team members provided examples of how they applied their professional judgement when delivering pharmacy services. Pharmacy team members had continual conversations about workload management and service delivery. And they engaged in regular briefings to discuss patient and workplace safety. The pharmacy had a whistle blowing policy and team members clearly understood how they would raise and escalate a concern at work. They provided examples of how their feedback was used. For example, when suggesting changes to stock placement in the dispensary to help reduce the risk of making a picking mistake when dispensing medicines.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, clean, and well maintained. It provides a professional environment for delivering healthcare services. People visiting the pharmacy can speak to team members in confidence in a well-equipped private consultation room.

Inspector's evidence

The pharmacy was secure and well maintained. The team were aware of how to report any maintenance concerns and there were no outstanding maintenance concerns requiring attention. The pharmacy was clean and organised throughout. Air conditioning provided a controlled temperature for delivering pharmacy services and for storing medicines, lighting was bright throughout the premises. Pharmacy team members had access to sinks equipped with antibacterial hand wash and paper towels.

The public area of the pharmacy was open plan, it provided seating for people waiting and it led to the medicine counter. The pharmacy's consultation room had a public entrance and a staff-only entrance. The room was a good size and offered a clean and professional private space for providing consultation services. Workflow in the dispensary was organised well with separate areas used for completing specific tasks, such as labelling and accuracy checking. The team used quieter areas of the dispensary for completing higher risk tasks such as measuring and reconstituting liquid medicines. To the back of the dispensary was access to staff facilities.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are accessible to people. It obtains its medicines from reputable sources. And it stores them safely and securely. The pharmacy regularly identifies people who may be struggling to take their medicines. And it demonstrates how it assesses the need to make any adjustments to support people in taking their medicines safely. The pharmacy team complete a range of audit trails to support it in managing queries about the services it provides. And it generally provides relevant information when supplying medicines to help people take them safely.

Inspector's evidence

People accessed the pharmacy through a door leading from the onsite carpark. The pharmacy advertised its opening times and details of its services for people to see. Pharmacy team members understood how to signpost people to alternative pharmacies or healthcare providers should the pharmacy be unable to provide a service or supply a medicine. The pharmacy had a leaflet explaining to people how they could share specific communication needs with team members.

Pharmacy team members were enthusiastic in engaging people in the pharmacy's consultation services. A team member providing the smoking cessation service provided an oversight of the service and discussed some of the benefits people reported when giving up smoking. The team had received recognition from the smoking cessation service provider in 2023 for its dedication and positive outcomes it achieved through the service. Information to support the safe delivery of consultation services and supplies of medicines through these services was readily available on a digital communication platform. The RP provided details examples of how people benefited from these services. For example, those diagnosed as having high-blood pressure through the blood pressure check service received timely referrals to the GP. After commencing on medicines, the RP supported them in using their new medicines through engaging with them through the New Medicine Service.

A team member explained how the team supported people struggling to take their medicines by having a discussion with them and completing an assessment tool. This helped to identify if the pharmacy needed to adjust the method of supply after liaison with the person's regular prescriber. For example, by providing medicines in daily or weekly instalments to support people in taking them safely. The team went on to complete a medicine stability tool if the outcome of the assessment were to supply medicines in multi-compartment compliance packs. This helped provide assurances that medicines supplied within compliance packs were suitable for dispensing in this way. The pharmacy had robust records to support it in managing the supply of medicines to people requiring adjustments. This included highlighting the method of supply on a schedule and completing an audit sheet identifying who had completed each part of the dispensing process. The team recorded changes to medicine regimens and the checks team members made to confirm these changes were clearly recorded on people's medication records. A sample of assembled multi-compartment compliance packs included descriptions of the medicines inside the pack. The pharmacy kept an audit trail of who had assembled and who had accuracy checked the compliance packs. But this information was not always recorded in full on assembled compliance packs for people to see. A team member was aware that the pharmacy should provide patient information leaflets at the beginning of every four-week cycle for people receiving their medicines in this way, but compliance with this varied.

Pharmacy team members used coloured baskets throughout the dispensing process. This process kept medicines with the correct prescription form and identified workload priority. They signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail for most medicines. The pharmacy had clear audit trails of the medicines it delivered to people and of the medicines it owed to people. And team members regularly checked prescriptions for owed medicines to help ensure people were kept informed of any supply problems. This helped ensure people did not run out of their medicine. The pharmacy sent some of its dispensing workload to the company's centralised dispensing hub pharmacy. This process was fairly new to the team and team members discussed the procedures and training they had undertaken ahead of completing the process. Ahead of implementing the service the pharmacy had reviewed its dispensing and handout processes. Team members spoke positively about the change and identified how it had supported the team in managing workload more effectively. Team members entered data to be sent to the dispensing hub pharmacy and there was a clear process and audit trails maintained to show that a pharmacist had clinically checked the prescription. The pharmacy only sent complete prescriptions to the dispensing hub pharmacy. Once the team received the dispensed medicine back, they matched the sealed bag with the relevant prescription and held them in a designated retrieval area.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. The RP had appropriate supervision over the medicine counter and public area and a team member explained how they would refer some requests for P medicines directly to the RP, such as repeat requests for higher-risk P medicines liable to abuse. The pharmacy had a process for identifying higher-risk medicines during the dispensing process. But it did not always highlight these medicines for additional counselling. Some medicines such as valproate were identified through stickers prompting referral to the RP to support compliance with the PPP. The team were aware of the legal changes to the supply of valproate requiring it to be supplied in the manufacturer's original box. The RP discussed how they had considered the risk of not supplying valproate in the manufacturer's original packaging in exceptional circumstances. But they had not completed a formal risk assessment to support them in supplying valproate in this way when needed. The team managed the risks of dispensing medicines for opioid treatment programmes well. There was a routine check of the measured quantity of medicine by an ACPT prior to the final accuracy check of the medicine taking place. The team made timely records of supply and contacted the local substance misuse team to raise queries.

The pharmacy obtained its medicines from licensed wholesalers, and it stored them neatly and within their original packaging. The pharmacy kept CDs securely in locked cabinets and it kept cold chain medicines in pharmaceutical fridges. It generally monitored the operating temperature range of its fridges across the working week, but records showed that checks were not always completed on a Saturday. The sample of records reviewed showed cold chain medicines were being stored between two and eight degrees Celsius as required. The pharmacy had appropriate medicine waste containers to support it in safely disposing of expired medicines and patient-returned medicines.

The team recorded the ongoing safety checks it made of the stock medicines it held, including date checks of medicines. The pharmacy student was completing a stock management project led by the pharmacy's head office to help establish the changes in local stock use following the implementation of the hub and spoke dispensing model. The long-term aim of the project was to identify changes to stock levels required to avoid medicine wastage. 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 team received and responded to safety alerts and medicine recalls through a digital monitoring platform.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It suitably maintains its equipment. And its team members use the equipment and facilities appropriately to protect people's confidential information.

Inspector's evidence

Pharmacy team members accessed most reference resources electronically via the internet, this helped to ensure they were accessing the most current information available. They used individual NHS smart cards and passwords when accessing people's medication records. Information displayed on the pharmacy's computer monitors was protected from unauthorised view through the layout of the premises. The pharmacy held bags of assembled medicines in large plastic boxes close to the medicine counter, and on shelves between the medicine counter and dispensary. Information on bag labels could not be read from the public area of the pharmacy.

The pharmacy had a range of 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. The team held equipment for its consultation services neatly within the consultation room. And it had processes for cleaning equipment between use. Where required, the pharmacy had single-use equipment such as earpieces for use with the otoscope and mouthpieces for use with the carbon monoxide meter. And it had safe processes for disposing of this equipment once used. The pharmacy's equipment was subject to regular monitoring checks to help ensure it remained safe to use and fit for purpose. Details of some of these checks were clearly annotated on the equipment to support team members in identifying when the next check was due.

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.