Registered pharmacy inspection report

Pharmacy Name: Lincoln Co-Operative Chemists Ltd, 3 High Street, Heckington, Sleaford, Lincolnshire, NG34 9RA

Pharmacy reference: 9010602

Type of pharmacy: Community

Date of inspection: 11/03/2020

Pharmacy context

This is a community pharmacy in a large rural village in Lincolnshire. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies some people with their medicines in multi-compartment compliance packs, designed to them to remember to take their medicines. And it provides a medicine delivery service to people's homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.1	Good practice	The pharmacy has robust review processes which help demonstrate how it manages risks associated with its services. And its team members understand how they personally contribute to managing risk.
		1.2	Good practice	Pharmacy team members act openly and honestly by sharing information when mistakes happen. They take part in regular safety reviews to share their learning. And they show how they act to reduce risk.
2. Staff	Good practice	2.2	Good practice	The pharmacy supports the learning needs of its team members through ongoing training and structured feedback.
		2.4	Good practice	Pharmacy team members work together well. They are enthusiastic about their roles. And they regularly share learning to improve safety.
		2.5	Good practice	The pharmacy encourages feedback from its team members in a number of ways. And it actively uses their feedback to inform its service delivery.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy team reaches out to the community to promote health and wellbeing. And it engages well with other organisations to support charitable events.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies the risks associated with its services. It has robust review processes which help demonstrate how it manages these risks. And its team members understand their job roles and how they personally contribute to managing risk. The pharmacy keeps people's private information secure. And it has appropriate arrangements for managing feedback and concerns. It keeps the records required by law up to date. And it has appropriate systems in place to support its team members in recognising and reporting safeguarding concerns. So, they are able to act to help protect the safety and wellbeing of vulnerable people. Pharmacy team members act openly and honestly by sharing information when mistakes happen. They take part in regular safety reviews to share their learning. And they show how they act to reduce risk.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). They covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The latest review of SOPs in 2019 had considered changes in dispensing processes following the introduction of the Falsified Medicines Directive (FMD). The pharmacy's superintendent pharmacist had recently changed. And a statement from the new superintendent at the front of the SOP folder confirmed he was satisfied the current set of SOPs should continue to be used.

The SOPs set out the roles and responsibilities of staff. And training records for members of the team confirmed that team members had read and understood SOPs relevant to their roles. A member of the team explained what tasks could and couldn't be completed if the RP took absence from the premises. And an accuracy checking technician (ACT) explained details of her role. The ACT confirmed she was confident in referring prescriptions to the pharmacist if she had any concerns. Pharmacists physically marked prescriptions prior to the accuracy check taking place to confirm they had clinically checked the prescription.

Workflow in the dispensary was organised. Work benches were clear of clutter and workload was effectively managed. Team members prioritised acute prescriptions. Labelling, assembly and accuracy checks took place in separate areas of the dispensary. And tasks associated with the multi-compartment compliance pack service were completed in a protected area out-of-sight of the public area. This provided a relatively distraction free environment for assembling packs.

The superintendent pharmacist was present during the inspection. He was in the process of reviewing the company's business continuity arrangements due to the growing situation associated with coronavirus. The pharmacy had prominent posters and information relating to coronavirus in key places. This included a poster on the pharmacy door which alerted people experiencing symptoms to not enter the pharmacy. And to instead return home and access NHS 111 for support. The pharmacy was in the process of finalising arrangements for its designated isolation room in accordance with the NHS England COVID-19 SOP.

Pharmacy team members discussed the near misses they made with the pharmacist or ACT. They entered these on a record in the dispensary. And serious near misses were recorded electronically

through Pharmapod. This provided the superintendent pharmacist's team with opportunities to share details of these types of mistakes and risk reduction strategies across all of the company's pharmacies. An ACT demonstrated how the pharmacy reported dispensing incidents through Pharmapod. And a sample of incident reports included use of a risk scoring matrix and learning points. Team members could demonstrate risk reduction actions they had taken following reported incidents. For example, the team had highlighted different strengths of atenolol on the dispensary shelves to prompt additional checks when picking medicines.

The pharmacy team had a proactive and consistent approach to sharing learning following mistakes and interventions. The RP led a monthly patient safety review. And team members were keen to demonstrate examples of ongoing risk reduction actions they were taking. For example, 'look-alike' and 'sound-alike' (LASA) medicines were prominently highlighted on dispensary shelves. And posters relating to the LASA medicines were displayed behind each stock location. This increased vigilance during the dispensing process. A team member demonstrated a personal learning record. This was in addition to the formal near miss record. The team member explained that each member of the dispensary team was encouraged to use the record to record their own personal mistakes. And she explained how this supported reflection of her own mistakes and helped her identify any trends or ask for support if required. For example, one team member had identified they were more likely to make a near miss after 5pm. They had discussed this with the RP and as a result of this reflection completed alternative tasks during the last hour of the day. Pharmacy team members were observed highlighting quantities and formulations of medicines on prescription forms. They explained how this process supported additional checks throughout the dispensing process, particularly if the quantity was unusual or formulation was not commonly dispensed.

The pharmacy had a complaints procedure. And it provided details of how people could leave feedback or raise a concern about the pharmacy through its practice leaflet and on a notice in the public area. It also promoted how people could leave feedback through the internet. A pharmacy team member explained how she would manage a concern. And the team referred any concerns it was unable to resolve to its head office for further investigation.

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 RP record complied with legal requirements. And the pharmacy manager left colour coded marks in the RP record to help identify what colour pen she had used to check prescriptions on a given day. The pharmacy's CD register was kept in accordance with legal requirements. The pharmacy maintained running balances in the register. And full balance checks took place at monthly intervals. 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. And a sample of entries examined complied with legal requirements. A sample of the pharmacy's specials records conformed to the requirements of the Medicine & Healthcare products Regulatory Agency (MHRA).

The pharmacy displayed a privacy notice. All pharmacy team members had completed mandatory information governance training. The pharmacy's annual NHS Data Security and Protection toolkit was submitted by its head office annually. It stored all personal identifiable information in staff only areas of the pharmacy. It transferred its confidential waste to 'Shred-it' bins. And the contents of these bins was securely destroyed at regular intervals.

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 could explain how they would recognise and report a safeguarding concern. They provided an example of signposting people to local organisations for support with organising meals and for companionship.

Principle 2 - Staffing   ✔ Good practice

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services safely. It supports the learning needs of its team members through ongoing training and structured feedback. The pharmacy encourages feedback from its team members in a number of ways. And it actively uses their feedback to inform its service delivery. Pharmacy team members work together well. They are enthusiastic about their roles. And they regularly share learning to improve safety.

Inspector's evidence

On duty during the inspection was the RP, a medicine counter assistant, a qualified dispenser, a pharmacy technician and two ACT's. The superintendent pharmacist was also present. And he was observed supporting the team during the inspection. The pharmacy also employed another medicine counter assistant and another qualified dispenser. A company employed delivery driver provided the pharmacy's prescription delivery service. One part-time team member had left the pharmacy in the last few months. The manager explained this position was not being filled. And the rota had been reviewed to support consistency in skill mix and staffing levels across the pharmacy's opening hours. The pharmacy could request support from the company's relief team if required.

Pharmacy team members completed regular learning and reflection to support them in developing their knowledge and skills. This training included e-learning modules on a range of topics, reading newsletters and attending out-of-hours events. For example, a team member discussed a recent asthma training event. The event had included teaching good inhaler technique. And the pharmacy was planning an event to promote world asthma day in 2020 which would provide further opportunities for team members to put the skills they had learnt into practice. Several pharmacy team members were also coming to the end of a healthy living champion course. Pharmacy team members confirmed they received some time in work to support them with their learning. The pharmacy had a structured appraisal system. This included one-to-one reviews between team members and their manager.

The pharmacy did have some targets associated with Medicine Use Reviews (MURs), the NHS Pharmacy Quality Scheme (PQS) and prescription switches. The RP was positive when discussing targets and provided examples of how she applied her professional judgment when delivering services. For example, she referred to previous MUR records when speaking with people again about their medicines. And provided several examples of how prescribers had taken onboard recommendations to change medicines due to people suffering from undesirable side effects. The pharmacy had been short listed for the company's 2020 'Branch of the Year' award which recognised the continual efforts being made by the team.

Pharmacy team members used a communication book to record messages and details of some daily tasks. And team members were encouraged to regularly read the book. The pharmacy held regular team meetings. These focussed on patient safety and workload management. Details of discussions from these meetings were captured within monthly patient safety reports. And pharmacy team members discussed actions from recent team meetings. The RP had produced a number of helpful resources to support the pharmacy team in managing tasks safely and effectively. For example, labelling and dispensing safety checklists. The checklists encouraged good practice and were aimed at reducing

the risk of a mistake being made during the dispensing process.

The pharmacy had a whistleblowing policy in place. Pharmacy team members were confident at explaining how they would share concerns with the RP in the first instance. And were aware of how to escalate concerns if required. A member of the pharmacy team demonstrated a staff suggestions box. And explained how team members regularly used this. Comments in the box were reviewed and discussed in team meetings. And team members provided examples of how their feedback was used to improve service delivery. For example, the team had created a 'prescription query note' which was used at the medicine counter during busy periods. The note was completed if a prescription could not be found in the prescription retrieval area. It included the persons details and the prescription details. And it was passed to the dispensary team for checks to be made. The note supported team members in protecting people's confidentiality at the medicine counter. And it allowed team members working at the medicine counter to move on to serve the next person, as another member of the team had taken over the query.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a professional environment for delivering 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 premises were secure. They were modern and well maintained. Team members reported maintenance concerns to a designated maintenance help desk. And they confirmed these were dealt with in a timely manner. The pharmacy was clean. It was air-conditioned. And lighting throughout the premises was bright. Floor spaces and workbenches were free from clutter. Antibacterial hand wash and paper towels were available at designated hand washing sinks.

The public area was open plan and accessible to people using wheelchairs and pushchairs. It provided seating for people waiting for prescriptions or a service. There was a clearly sign-posted consultation room. The room was a good size and it was professional in appearance.

The dispensary was a good size for the level of activity being carried out. There was protected work bench space in a separate area of the dispensary for managing tasks associated with the multi-compartment compliance pack service. Staff facilities also led off the dispensary. And a small room at the back of the pharmacy was used to store some dispensary sundries such as Electronic Prescription Service (EPS) tokens. These items were held at floor level. But the fire exit leading off the room remained accessible.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. The pharmacy team reaches out to the community to promote health and wellbeing. And it engages well with other organisations to support charitable events. The pharmacy has suitable procedures to support its team members in delivering its services effectively. And its team members take time to speak to people about their medicines. The pharmacy obtains its medicines from reputable sources. And it manages them appropriately to help make sure they are safe to supply.

Inspector's evidence

People accessed the pharmacy through a power assisted door at street level. The pharmacy advertised its opening hours and details of its services. It had a range of information leaflets promoting healthy living and providing information about chronic diseases and high risk medicines available for people to take. Pharmacy team members were aware of how to signpost people to another pharmacy or healthcare provider if they were unable to provide a service.

The pharmacy offered a range of private healthy living services. This included screening checks for blood pressure and blood glucose. It referred people to their GP for further examination if results from these checks were abnormal. The RP explained there had been a recent increase in people accessing the pharmacy's weight loss service. This service involved providing people with regular weigh-ins, practical guidance and tips and dietary information from the NHS 'One You' website. The pharmacy also engaged people in conversations related to national health campaigns. And it displayed promotional material to support these campaigns.

The pharmacy engaged with the local community well. It regularly supported healthcare charities through its promotional events. This had recently included collecting spectacles as part of a recycling scheme for third-world countries. The pharmacy had also supported events in the community involving the company's health pod. For example, at the village show in 2019. The health pod involved people being able to access health checks. And provided an opportunity for people to ask questions and seek advice from pharmacy team members, including pharmacists.

The pharmacy had some processes for managing higher risk medicines such as warfarin, lithium and methotrexate. For example, people collecting their own prescriptions were asked for details of their INR monitoring. And a sample of records confirmed this process was regularly followed. The RP acknowledged that carers and people using the pharmacy's prescription delivery service were not always asked for details of monitoring checks associated with managing high-risk medicines. The pharmacy was not regularly dispensing valproate to people in the high-risk group. It had participated in several audits associated with higher-risk medicines and chronic diseases through the NHS PQS. And this had included a valproate safety audit. Pharmacy team members could discuss the requirements of the valproate pregnancy prevention programme (PPP). And the pharmacy had high-risk warning cards ready to issue to people.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form. And it helped to identify workload priority. Pharmacy team members signed

the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. They also completed relevant sections of an audit grid on prescription forms. The grid identified who had been involved in the dispensing process. And confirmed prescriptions had been clinically checked by a pharmacist. A sample of dispensed prescriptions confirmed this audit trail was in regular use. The pharmacy team kept original prescriptions for medicines owing to people. The prescription was used throughout the dispensing process when the medicine was later supplied.

People receiving their medicines through the pharmacy's delivery service were asked to sign for receipt of their medication. The pharmacy was due to change the way it dispensed prescriptions for people on the delivery service. This was due to the company opening a centralised pharmacy to manage these prescriptions and the delivery service. The pharmacy was requesting consent from people using the service ahead of the changes being applied. And a leaflet about the changes was being provided to each person on the service.

The pharmacy was able to order prescriptions from surgeries for people receiving their medicines in multi-compartment compliance packs. It had a process for checking details of these prescriptions against individual profile sheets for each person receiving their medicines in this way. And it kept an audit trail of each stage of the process to help all team members answer queries associated with the service. The team recorded changes to people's medication regimens clearly on designated cards held within plastic wallets with individual profile sheets. A sample of assembled packs contained dispensing audit trails. The pharmacy provided descriptions of medicines inside the packs to help people identify them. And it supplied patient information leaflets with packs at the beginning of each four-week cycle. It also isolated original packaging of medication used to fill multi-compartment compliance packs up until the next pack was assembled. This allowed team members to check any information relating to the medicines dispensed. For example, the batch number of a medicine in the event of a drug recall. And it supported team members in answering queries if they arose mid-cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members were knowledgeable about the requirements of the FMD. And an ACT demonstrated how the pharmacy complied with FMD requirements when dispensing medicines in compliant packaging. Pharmacy team members circled quantities on medication labels if the packaging was not tamper-proof. This prompted additional checks during the dispensing process. And team members clearly marked split boxes to reduce the risk of a quantity error during the dispensing process. And the risk of attempting to scan a medicine which had already been decommissioned.

The pharmacy stored Pharmacy (P) medicines behind its medicine counter. It stored medicines in the dispensary on shelves in an orderly manner. Most medicines in the dispensary were held within their original packaging. But some tablets for use when assembling multi-compartment compliance packs were found in an unlabelled amber bottle, held inside the original box of medication the tablets had been removed from. A discussion took place about the risks associated with this practice. CDs were held in secure cabinets. They were an appropriate size for the amount of stock held. And there was room for segregating out-of-date and patient returned CDs within the cabinets. It held its cold chain medicines in a medical fridge. Temperature records confirmed the fridge was operating between two and eight degrees Celsius as required.

A date checking rota was in place. And this confirmed regular date checks took place. The pharmacy kept a list of short-dated medicines. And it clearly highlighted these medicines on the dispensary shelves. A random check of dispensary stock found no out-of-date medicines. But some out-of-date single use lancets were found in the consultation room. These were removed and brought to the attention of the RP. This prompted checks to ensure the medicine remained safe and fit to supply to

people.

The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste. It received details of medication recalls and drug alerts electronically. And it kept a copy of these alerts with details of any action it had taken. The team demonstrated how all alerts were actioned to date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And pharmacy team members act with care by using the pharmacy's equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for children. Pharmacy team members could access additional resources through the internet. The pharmacy's computer system was password protected. 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 designated shelves to the side of the dispensary. And information on prescription forms and bag labels could not be read from the public area. Pharmacy team members used a cordless telephone handset. This meant they could move out of ear-shot of the public area when having confidential telephone conversations.

The pharmacy had a range of crown stamped measuring cylinders for measuring liquid medicines. It had clean counting equipment for tablets and capsules. And it stored some equipment to support the delivery of services within its consultation room. This included a glucometer and blood pressure machine used for screening services only. Some out-of-date lancets were found in the consultation room alongside this equipment. These were removed and brought to the attention of the RP. The pharmacy's electrical equipment was subject to periodic safety checks. A certificate indicated these checks were next due in December 2020.

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.