General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lincoln Co-Operative Chemists LTD, 451 Newark Road, North Hykeham, Lincoln, LN6 9NG

Pharmacy reference: 9011123

Type of pharmacy: Community

Date of inspection: 24/09/2019

Pharmacy context

This community pharmacy relocated to a newly built Lincolnshire Co-operative food store in Spring 2019. It is located on a main road leading into the city of Lincoln. 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 through its NHS services. It facilitates podiatry clinics. And it offers some healthy living services including a weight management programme and blood pressure checks. It supplies medicines in multi-compartmental 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

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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	3.2	Good practice	Pharmacy team members actively promote the availability of the pharmacy's private consultation rooms. And these rooms are fitted to a high standard and are well equipped.
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 identifies and manages the risks associated with its services. It keeps people's private information secure. And it keeps the records it must by law. The pharmacy has appropriate arrangements in place for managing feedback and concerns. The pharmacy promotes a clear culture of safeguarding the safety and wellbeing of vulnerable people. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they makes changes to their practice to improve patient safety.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The last review of SOPs had been completed in April 2019, ahead of the scheduled review date of September 2019. This decision had been influenced by changes to dispensing practices introduced by the Falsified Medicines Directive (FMD). Pharmacy team members explained they generally read the electronic version of SOPs available to them. But they had yet to sign to confirm they had read and understood the changes to SOPs following the 2019 review. They were observed working in accordance with sales of medicines and dispensing SOPs during the inspection. And a member of the team explained what tasks could and couldn't be completed if the responsible pharmacist (RP) took absence from the premises.

Pharmacy team members organised their workload well. And they had ample space in the dispensary to manage workflow. A pharmacy team member explained how there was a shift in the pharmacy's balance of workload following the move to the new premises. For example, the pharmacy had moved away from the surgery it received most of its prescriptions from. This had meant the pharmacy team now processed more repeat and less acute prescriptions. The pharmacy employed an accuracy checking technician (ACT). The ACT received some protected time each week to maintain her competencies in checking. And the pharmacy had established processes to ensure prescriptions were clinically checked by the pharmacist prior to the ACT undertaking accuracy checks. For example, one morning each week the RP labelled and completed his clinical checks of the prescriptions prior to the ACT performing the final accuracy check.

Pharmacy team members took ownership of their mistakes by discussing them with the pharmacist or ACT. They generally recorded details of their mistakes. But there were some months when very few near-miss errors had been recorded. For example, one near-miss error was recorded in March 2019. Pharmacy team members explained how they were making active efforts to record their own mistakes. And their records included good oversight of the factors which had contributed to mistakes. But actions recorded within the near-miss error record focussed on what was done to correct the mistake at the time it occurred, rather than any risk-reduction actions the team had applied. Pharmacy team members discussed their mistakes. But the pharmacy did not record details of these discussions. This meant there could be some missed opportunities to share learning. And to review the effectiveness of any actions taken. Pharmacy team members could demonstrate how they acted to reduce the risk of similar mistakes occurring. For example, rosuvastatin and rivaroxaban was separated and labelled in the dispensary drawers to reduce the risk of picking error. And all strengths of warfarin were stored in colour coded sections of the dispensary drawers to prompt additional checks during the dispensing process.

The pharmacy followed the company's incident reporting processes by reporting dispensing errors through 'pharmapod'. The RP confirmed he had not needed to report any concerns since taking over as manager in spring 2019. Pharmapod contained details of historic incidents. And the superintendent pharmacist had reviewed these and provided follow-up actions to the pharmacy team. Pharmacy team members discussed the increased support they had received during a period of time in their old premises when incident rates had increased.

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 a notice in the public area. A member of the team explained how she would manage a complaint and understood how to escalate concerns if required. The pharmacy had received some feedback from people about its door, as it kept this closed during the working day. Pharmacy team members explained this was due to noise levels in the food store, and particularly the volume of the instore music. They discussed how they would assist people by opening the door for them if required. The RP explained how he had responded to concerns from people who had read media reports about medicines shortages affecting pharmacies.

The pharmacy had up-to-date indemnity insurance arrangements in place through the National Pharmacy Association (NPA). The RP notice contained the correct details of the RP on duty. Entries in the responsible pharmacist record complied with requirements. The Prescription Only Medicine (POM) register was held electronically. All information legally required was recorded although the patient record had to be accessed to view details of the prescriber and prescription date. Details of emergency supplies were recorded in full. The pharmacy kept specials records with an audit trail from source to supply of the unlicensed medicine dispensed. The pharmacy maintained running balances in its controlled drug (CD) register. And it completed weekly stock checks of the register against physical stock. A sample of the register confirmed it was maintained in accordance with legal requirements. And a physical balance check of MST Continus 10mg tablets complied with the balance recorded in the register.

The pharmacy displayed a privacy notice. It stored people's personal information in staff only areas of the pharmacy. And pharmacy team members demonstrated how their working processes kept people's information safe and secure. They had completed additional learning of data protection requirements following the introduction of the General Data Protection regulation (GDPR). And SOPs highlighted confidentiality requirements. The pharmacy disposed of confidential waste through transferring it to designated Shred-it bins. The contents of the bins were securely disposed of via the waste management contractor.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. This information included contact details for local safeguarding agencies. The RP and ACT had completed level two safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE). And certificates of training for other members of the team included learning related to modern slavery, safeguarding and dementia. A dispenser had documented a reflective account of the steps she had taken to support a carer who was struggling. This had included researching and passing on information of a local support group. Pharmacy team members demonstrated a sound understanding of how to recognise and report safeguarding concerns. And they followed good processes for monitoring the collection and delivery of medicines supplied in multi-compartmental compliance packs. A dispenser explained how missed deliveries or uncollected packs would result in the pharmacy contacting the person or their GP to check on their health and wellbeing.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services effectively. It responds appropriately when additional staffing resources are required to support the safe running of the pharmacy. The pharmacy promotes how its team members can provide feedback. It acts appropriately by responding to this feedback. And by supporting team members who raise concerns. The pharmacy encourages its team members to engage in ongoing learning relating to their roles. And pharmacy team members engage in regular conversations about managing their workload and patient safety.

Inspector's evidence

On duty throughout the inspection was the pharmacy manager (RP), a qualified dispenser and a trainee dispenser. The pharmacy also employed another qualified dispenser, a medicine counter assistant and an ACT. A company employed driver completed tasks associated with the prescription collection and delivery service.

The pharmacy was experiencing some acute staffing issues, caused by short-term absence of two pharmacy team members and one long-term planned absence. The situation had resulted in the manager attending for work one morning to no support staff. He explained how he had not signed in as RP or opened the pharmacy until he had felt assured that the pharmacy was able to operate safely. And the area manager had arranged for immediate support staff to be deployed to the pharmacy to help manage the situation. Pharmacy team members confirmed there was some flexibility within the team. For example, the trainee dispenser had increased her hours to help cover the long-term absence. And the manager confirmed he was able to contact his area manager and request support when needed. The pharmacy's workload was up to date on the day of inspection. And waiting times for prescriptions were short.

Pharmacy team members reported receiving some training time at work. The manager had set out a schedule for protected training time for a dispenser who was enrolled on a level three course in pharmacy services. And also, for the trainee dispenser. But pharmacy team members did not always take this time as they were committed to ensuring dispensing tasks were up to date. The pharmacy team members worked well together and identified how they encouraged each other to take time for training. All members of the pharmacy team engaged in ongoing learning relating to their roles. This involved reading newsletters and completing regular e-learning.

The pharmacy had a structured appraisal process. But it had been over a year since pharmacy team members had their last review. This was due to management changes and a period of time where relief pharmacists had supported the pharmacy. Pharmacy team members had recently been provided with a copy of their appraisal paperwork ahead of a planned review. The pharmacy did have some targets in place. The RP expressed that he was supported in applying his professional judgement when working towards meeting targets. He explained there was less opportunities to complete some services such as the New Medicine Service (NMS) due to the pharmacy receiving less walk-in workload since relocating. Pharmacy team members supported the pharmacist in identifying people who could benefit from the services provided during the dispensing process.

The pharmacy team shared information relating to workload management and patient safety informally, through conversation. The team did not meet to hold structured meetings. A discussion took place about how structured meetings could help to maximise shared learning opportunities. And assist pharmacy team members not on duty by ensuring they were up to date through reading through the learning outcomes. The pharmacy had a whistleblowing policy in place. And pharmacy team members were confident in reporting and escalating concerns when required. Pharmacy team members shared details of a historic concern during the inspection. They confirmed they had felt well supported by the superintendent pharmacist's team through this process. And the feedback had been used to inform positive changes within the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a professional environment for delivering healthcare services. Pharmacy team members actively promote the availability of the pharmacy's private consultation rooms. And these rooms are fitted to a high standard and are well equipped.

Inspector's evidence

The pharmacy was in a purpose-built retail unit at the back of the food store. It was secure and well maintained. Pharmacy team members could report maintenance concerns to a designated support desk. The pharmacy was bright and clean throughout. Work benches were clear of clutter and floor spaces were free of trip hazards. Antibacterial soap was available at designated hand washing sinks, including within the pharmacy's consultation room and podiatry suite. The pharmacy had appropriate air-conditioning and heating arrangements.

The public area was open plan. It stocked a range of health-related products and medicines. The dispensary was located beyond the medicine counter. It was a good size with plenty of space for managing the volume of work. Workflow was efficient and safe. For example, multi-compartmental compliance packs were assembled on a designated bench at the back of the dispensary. This reduced the risk of interruptions during the dispensing process.

The pharmacy had a designated podiatry suite, consisting of two rooms. One room was well equipped for medical consultations. And a small room to the side was used to store and clean equipment. A private consultation room was available next to the podiatry suite. The room was well sign-posted and modern in appearance. And pharmacy team members used the room with people throughout the inspection. Both rooms were fitted to a high standard with effective sound proofing. And they were protected from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and ensures these are accessible to people. It has up-to-date procedures to support the pharmacy team in delivering its services. And pharmacy team members work effectively with other healthcare providers. This helps to ensure people receive timely access to the medicines they require. The pharmacy obtains its medicines from reputable sources. It stores and manages its medicines safely and securely.

Inspector's evidence

The pharmacy was clearly signposted from the main road. It was located at the back of the food store. Some boxes of stock held above display shelves in the food store did make it difficult to see the pharmacy from the entrance. Pharmacy team members had fed back concerns about this. And in response additional signage directing people to the pharmacy had been fitted within the food store. There was step-free access into the store and parking was available onsite. The pharmacy advertised details of its opening times and services clearly. It had a small health promotion zone. And a good range of leaflets relating to services, chronic diseases and healthy living where available for people to take. The pharmacy provided seating for people whilst they waited for a prescription or service.

Pharmacy team members were aware of sign-posting requirements should the pharmacy be unable to provide a service or medicine. They explained how they had sign-posted people to local support groups and had received positive feedback from people who had found these groups helpful. The weight management programme was popular. The trainee dispenser discussed positive outcomes from the programme to people's health and wellbeing. And she explained how she tailored the advice and information provided to help people achieve their goals. For example, to help support a long-term change to lifestyle, people were encouraged to make healthy swaps in their meals. The podiatry service was provided by a company employed podiatrist. The pharmacy advertised details of this service. And pharmacy team members facilitated bookings for these clinics.

The RP was in the final stages of planning prior to launching a smoking cessation and flu vaccination service. Training records and information relating to the services was available for inspection. And the pharmacy had up-to-date patient group directions (PGDs), anaphylaxis supplies, and sharps bins ready to begin the seasonal flu vaccination service. The pharmacy team annotated assembled bags of medicines with stickers to help identify eligible people for some of the pharmacy's services. The RP reflected on how Medicines Use reviews (MURs) were used as an opportunity to improve people's knowledge about the medication they were taking. And to answer any queries. For example, concerns about side effects.

The pharmacy displayed posters and information relating to high-risk medicines within the dispensary. This included details of counselling requirements for supplying valproate in accordance with the valproate pregnancy prevention programme (PPP). Pharmacy team members identified high-risk medicines during the dispensing process. The RP explained how he would provide verbal counselling and monitoring checks when handing out these medicines. But the pharmacy did not regularly record the outcomes of these discussions.

The pharmacy used a planner to support workload associated with the multi-compartmental compliance pack service. The team ordered repeat prescription for medicines dispensed inside these packs. And it made appropriate checks prior to ordering prescriptions for other medicines such as inhalers and creams. Individual profile sheets were in place for each person on the service. And the team generally used these well to track changes to medication regimens. A pharmacy team member was observed checking prescriptions against backing sheets prior to beginning dispensing. And she was also observed undertaking a thorough check of her work prior to informing the pharmacist that an accuracy check was required. A sample of assembled packs contained full dispensing audit trails. The pharmacy provided descriptions of the medicines inside the pack to help people identify them. And it supplied patient information leaflets at the beginning of each four-week cycle of packs. But it did not secure backing sheets to packs. A discussion took place about the risks associated with not securing these sheets in a safe manner.

The pharmacy used 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 it used the prescription throughout the dispensing process when the medicine was later supplied. The RP explained how GPs would telephone the pharmacy for advice relating to suitable alternatives when medicines were out of stock. And the pharmacy shared information about stock issues with GP surgeries. The pharmacy kept an audit trail for its delivery service. People were asked to sign for receipt of their medicines through the service.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It had a system which allowed staff to comply with the requirements of the Falsified Medicine Directive (FMD). And a dispenser demonstrated how pharmacy team members used the system when dispensing medicines in FMD compliant packaging. The pharmacy team received drug recalls via email. It acted upon these alerts in a timely manner and kept a copy for reference purposes.

The pharmacy stored Pharmacy (P) 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. Most medicines were stored in drawers. And the team had risk-assessed these storage arrangements to avoid unnecessary climbing and reaching when picking medicines. The pharmacy team followed a date checking rota to help manage stock and it recorded details of the date checks it completed. One area of the dispensary was showing as over-due on the rota. Short-dated medicines were identified and the team annotated details of opening dates on bottles of liquid medicines. No out-of-date medicines were found during checks of dispensary stock. Medical waste bins and CD denaturing kits were available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in a secure cabinet. Medicine storage inside the cabinet was orderly. There was designated space for storing patient returned, and out-of-date CDs. Prescriptions attached to bags of assembled CDs were clearly highlighted. This enabled the pharmacist to check the validity of the prescription before supplying a CD. And it prompted additional checks throughout the dispensing process.

The pharmacy's fridge was clean and stock inside was stored in an organised manner. The pharmacy team monitored fridge temperatures. And records confirmed the fridge was generally operating between two and eight degrees Celsius as required. Pharmacy team members had recorded reasons why the fridge temperature had been above eight degrees Celsius on occasion. For example, when cleaning and date checking the fridge. The team member had re-set the thermometer and performed

an additional check when this had occurred to ensure the temperature had returned to the required range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors its equipment to ensure it remains safe to use. And pharmacy team members manage and use 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. And it had quick links to commonly used websites on the main dispensary computer. For example, nhs.uk. The pharmacy's computer system was password protected. And pharmacy team members on duty had their own NHS smart cards which they used to access medication records. Information on computer monitors was protected from unauthorised view through the layout of the premises. The pharmacy stored assembled bags of medicines on allocated shelving within the dispensary. This protected information on bag labels and prescription forms from unauthorised view. Pharmacy team members used cordless telephone handsets. This meant they could move out of ear-shot of the public area when having confidential telephone conversations.

The pharmacy had clean, crown-stamped measuring cylinders for measuring liquid medicines. It had clean counting equipment for tablets and capsules. This included a separate triangle for use when counting cytotoxic medicines. This triangle was stored in a clear bag to prevent the risk of cross-contamination with other equipment. A suitable range of equipment was available to support pharmacy team members in assembling multi-compartmental compliance packs. For example, single use gloves and medical tweezers. The pharmacy used an Omron blood pressure machine, and it replaced this periodically. A certificate relating to electrical safety testing confirmed these checks had last been carried out in September 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.