General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lincoln Pharmacy, 124 St. Pauls Way, London, E3 4QA

Pharmacy reference: 9011183

Type of pharmacy: Community

Date of inspection: 30/08/2024

Pharmacy context

The pharmacy is located within a GP practice in East London. It provides NHS dispensing services, the Pharmacy First service, the New Medicine Service, and blood pressure checks. It also provides the emergency contraception service, COVID-19 vaccination and flu vaccination services via patient group directions. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own homes and need this support.

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 generally identifies and manages the risks associated with its services. It records and reviews any mistakes that happen during the dispensing process. It protects people's personal information. Team members understand their role in protecting vulnerable people. And the pharmacy largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which were held electronically and were easily accessible to the team. Current members of the team had signed a training record to show that they had read and understood the SOPs. Team members' roles and responsibilities were specified in the SOPs.

Team members said that mistakes had significantly reduced due to the dispensing robot. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Near misses were recorded and reviewed regularly to help identify any patterns or trends. Any learning points were discussed with the wider team during team meetings but were not routinely documented. This may make it difficult to assess if a learning point had been actioned. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was completed. The team members said that the pharmacy had not had any recent dispensing errors. There was a clear workflow and designated areas for various tasks. Workstations in the dispensary were tidy and free from clutter.

The pharmacy had in-date professional indemnity insurance. The correct responsible pharmacist (RP) notice was displayed, and the RP record was completed correctly. The pharmacy was not providing many emergency supplies and instead signposted people to the NHS 111 service. The nature of the emergency was seen to be recorded when a supply of a prescription-only medicine was supplied in an emergency. The private prescription records were largely completed correctly, but the correct prescriber details were not routinely recorded. Team members said that they would maintain complete records about private prescriptions in the future. Controlled drug (CD) registers examined were filled in correctly. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

The complaints procedure was displayed in the retail area for people to refer to should they wish to raise a complaint or provide feedback. Complaints were referred to the pharmacy manager who would investigate them and provide a response to the person raising the complaint. They were also discussed during team meetings to help identify any learning needs.

Confidential waste was removed by an approved waste contractor, computers were password protected and computer screens faced away from people. Individual smartcards were used to access the NHS spine. Bagged items awaiting collection could not be viewed by people using the pharmacy. Team members had completed training about protecting people's personal information. The pharmacy had three consultation rooms which could be used for private conversations. Team members were observed asking people collecting their medicines to write their details down and discreetly confirming details.

Team members had completed training about protecting vulnerable people. And the pharmacy had the contact details of local safeguarding teams. Members of the team were able to describe signs of abuse and neglect and said that they would refer any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough members to provide its services safely. They are provided with some ongoing training to support their learning needs. And they have regular meetings where they can raise concerns or make suggestions.

Inspector's evidence

During the inspection, the pharmacy was staffed by the superintendent pharmacist (SI), two other pharmacists, a pharmacy technician, three trainee pharmacy technicians, a dispenser and two work experience students. The pharmacy also employed another dispenser and a trainee medicine counter assistant (MCA) who were not present during the inspection. All members of the team were either suitably qualified for their role or enrolled onto the relevant course. There were contingency arrangements for staff cover if needed. The pharmacy was up to date with its workload, and team members were observed communicating effectively and working well together. Team members covering the medicines counter asked the appropriate questions before selling Pharmacy-only medicines (P-medicines). They were aware of medicines which were liable to misuse and described how they would handle multiple requests for these. And they knew that they should not hand out any dispensed items or sell any pharmacy-only medicines if a pharmacist was not present at the pharmacy.

Team meetings were held regularly to discuss any complaints, issues, and changes. Information was also communicated via a team group chat. Staff performance was discussed informally. Team members said that they were comfortable to raise concerns or give feedback to the pharmacists and their colleagues. Targets were not set for the team.

Team members had access to online modules, for example, from e-Learning for health, and tried to regularly complete training to help keep their skills and knowledge up to date. They were generally not allocated protected time during work to complete ongoing training. The SI said that they made sure that all team members were up to date on antimicrobial stewardship, safeguarding, and data protection. The team also had access to pharmacy magazines, leaflets, and booklets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean, bright, and fitted to a high standard. It comprised of a spacious shopfloor and a dispensary on one side of the shop. The dispensary was fitted with a dispensing robot and had ample storage and workspace. Workbenches were kept clean and tidy. The shopfloor was well maintained and had several seats for those waiting for prescriptions or services. There were three spacious consultation rooms which were fitted with computers, sinks, and therapy beds. The doors of the consultation rooms were fitted with a Digi-lock and were kept always locked.

P-medicines were kept behind the medicines counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. There were two large TV screens behind the medicines counter which were used to promote services.

Air conditioning was available, and the room temperature was suitable for storing medicines. Team members had access to a kitchenette, which was fitted with a separate fridge for storing food, and clean toilet facilities.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. And the pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

There was step-free access into the pharmacy via two entrances, one from the main road and the other from the GP practice. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The pharmacy had recently introduced a mobile telephone App where people could find out more about its services and book appointments. Team members said they actively signposted people to services and highlighted prescriptions for people who were eligible for a service. Some members of the team were multilingual which helped particularly as there was a large Bengali community in the area. Some members assisted in translating during consultations or when pharmacists provided services.

Most prescriptions were received electronically and were dispensed by the dispensing robot. Team members said that the dispensing robot had significantly improved the dispensing process and reduced errors. Prescriptions were scanned onto the dispensing system before stock was selected automatically by the dispensing robot. The medicines were then labelled by member of the dispensary team before they were checked by a pharmacist. Baskets were used to separate prescriptions to prevent transfer between patients. The dispensed by and checked by boxes on the labels were seen to be routinely used, and this helped identify who was involved in these processes. Team members were observed confirming the person's details before handing out medicines.

The pharmacists said that the dispensing system automatically flagged up higher-risk medicines such as lithium and methotrexate. They said that they spoke with people when they collected their medicines and provided them with additional counselling. However, they did not maintain any records of checks made or advice given. There was one person who was supplied with a medicine which required ongoing monitoring and both pharmacists did not know when they were last monitored by their prescriber. Team members were aware of the additional guidance when dispensing sodium valproate and the need to make additional checks, for example, if the person was on a Pregnancy Prevention Programme (PPP). The team were not aware of the new government restrictions on the use of puberty suppressing hormones and said that would look into it.

The pharmacy did not order prescriptions on behalf of people who received their medicines in the packs. Instead, people were asked to contact the pharmacy to order their prescriptions. This helped reduce medicine wastage. The pharmacy kept a record for each person which included any changes to their medication. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were provided to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

In date patient group directions (PGDs) were available for the Pharmacy First and vaccine services provided at the pharmacy. The pharmacists had completed all the relevant training. Relevant records

were maintained for both services. A checklist was clearly displayed to help people assess their eligibility for the Pharmacy First service. The pharmacists providing GP referral slips, containing information on why the person was signposted back to their GP, if a supply was not suitable.

Medicines were obtained from licensed wholesalers and stored appropriately. Most medicines were stored inside the dispensing robot. Medicine packs were scanned by the robot before being stored. The robot carried out regular expiry-date checks and highlighted any medicines which were due to expire. Expiry-date checks of medicines stored outside the robot were done regularly and records were maintained. No date-expired medicines were seen on the shelves checked. Fridge temperatures were monitored daily and recorded; records seen were within the required range for storing temperature-sensitive medicines. Waste medicines were separated and collected by a licensed waste collector. Drug recalls were received by email. The team members said that they would action alerts as soon as they were received and retain them for reference. Several recent alerts were seen to have been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines and prevent contamination. Triangle tablet counters were available and clean. The blood pressure monitor was labelled with the date of first use and team members said that it would be replaced or calibrated annually. The ear suction device was cleaned regularly and serviced annually. Disposable tips were used. There were two pharmaceutical fridges in the dispensary and another two in the consultation rooms. The phone in the dispensary was portable so it could be taken to a more private area where needed. Up-to-date reference sources were available in the pharmacy and online.

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.