General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lincoln Co-Operative Chemists Ltd, 5 Proctors Road, Lincoln, Lincolnshire, LN2 4LA

Pharmacy reference: 9011297

Type of pharmacy: Closed

Date of inspection: 14/10/2021

Pharmacy context

This distance selling pharmacy opened in February 2020. It is co-located with the company's medicine wholesale warehouse and pharmacy head office. The pharmacy specialises in dispensing prescriptions to be delivered to people's homes through a centralised delivery service. The premises are not physically accessible to members of the public due to the distance selling model in place. This inspection took place during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 keeps a comprehensive risk register which it reviews regularly. And it has effective control measures that support it in managing the risks associated with providing its services.
		1.4	Good practice	The pharmacy encourages feedback from service users. And it is good at acting on the feedback it receives to inform the safety and quality of its services.
		1.8	Good practice	Pharmacy team members are vigilant in carrying out their roles. They act by reporting safeguarding concerns appropriately. And they work well with other healthcare professionals and safeguarding agencies to help keep people from harm.
2. Staff	Standards met	2.4	Good practice	Pharmacy team members are enthusiastic about their roles. They are encouraged to share learning following mistakes. And they work together well by supporting each other's individual learning needs.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.3	Good practice	The pharmacy has good systems to ensure it stores and manages its medicines safely and securely. This includes monitoring access to higher risk medicines. And having effective processes for ensuring medicines are safe and fit to supply to people.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy carefully considers the risks of the services it provides. It keeps a comprehensive risk register which it reviews regularly. And it has effective control measures that support it in managing the risks associated with providing its services. The pharmacy keeps people's information secure. And it maintains its records in accordance with legal requirements. It encourages feedback from people using its services. And it listens to and acts upon feedback to inform the safe and efficient management of its services. Pharmacy team members demonstrate a good understanding of their roles and responsibilities. And they engage in regular discussions designed to improve the safety of the pharmacy services provided. They are good at identifying and reporting safeguarding concerns. And they work with other healthcare professionals and safeguarding agencies to help keep people safe from harm.

Inspector's evidence

The pharmacy had considered the risk of providing its services during the pandemic. There was evidence of standard operating procedures (SOPs) and a premises risk assessment to support team members working through the pandemic. Team members had signed these documents to confirm their understanding of them. Stickers on the dispensary floor helped team members to socially distance whilst working. And the team had set up a one-way system when picking stock from the dispensary shelves. The pharmacy permitted one team member at a time to work in each stock aisle as the aisles were narrow. This also helped to create a distraction free environment. And as such reduce the risk of team members making a mistake when picking a medicine. Team members had supplies of personal protective equipment (PPE) available to them. They had completed learning associated with donning and doffing PPE correctly. And they routinely wore type IIR face masks when working.

The pharmacy had a comprehensive risk register. It managed this document through version control and the document was regularly updated. The register identified potential risks to the business model. And it set out controls and monitoring processes to support management of each identified risk. Each risk was scored using an impact and probability matrix. And the scoring system clearly identified how the control measures effectively reduced each risk. The register considered the safety of the services provided, team training requirements and business continuity arrangements. The pharmacy team described an example of how it had managed an acute staffing issue during the pandemic. This was noted to be in accordance with the control measures identified in the risk register.

The pharmacy had a set of up-to-date SOPs designed to support the safe running of the pharmacy. These clearly covered how the pharmacy provided its services at a distance. Training records associated with the SOPs were available for inspection. Pharmacy team members demonstrated a clear understanding of their roles and when to refer queries to the responsible pharmacist (RP). The pharmacy employed two accuracy checking technicians (ACTs). An ACT demonstrated how audit grids on prescription forms clearly identified that a clinical check of a prescription by a pharmacist had taken place prior to the accuracy check beginning. Personnel within the delivery administration team had also read and signed some pharmacy SOPs. This helped to provide them with the knowledge and information they required to carry out their roles effectively.

In addition to signing the 'dispensed by' and 'checked by' boxes on dispensing labels, team members also signed the audit grid on prescription forms to indicate who had labelled the prescription,

assembled the medicine and accuracy checked the medicine. This helped provide feedback to team members involved in a near miss mistake. The pharmacy encouraged team members to record their own near misses by displaying notices throughout the dispensary. The notices included a quick response (QR) code which team members scanned. This took them to the company's electronic near miss recording template. The process encouraged near miss recording at all stages of the dispensing process. A team member demonstrated the process for recording near misses. The team member explained that feedback and discussions about mistakes regularly took place. These discussions supported team members in reflecting on why a mistake occurred, and in completing the near miss record. Each team member corrected their own near misses whenever possible. Team members spoke openly about their mistakes and shared ideas about how to manage risk. But not all team members took every opportunity to record details of their near misses.

The pharmacy had an electronic incident reporting process. This provided team members with an opportunity to formally record and reflect on dispensing incidents. The team comprehensively completed the incident reporting process and the RP provided assurance that all incidents were recorded. Records clearly identified contributing factors and sought to identify the root cause of these type of mistakes. The team recorded the actions it took to reduce risk following a dispensing incident. And a review of some recent actions designed to reduce risk found them to be fully implemented.

The pharmacy manager and team leader led a monthly patient safety review with the team. This included reviewing a trend analysis report of near misses and dispensing incidents produced by the online reporting system. The team had identified an opportunity to increase formal recording of near misses during reviews. A discussion took place about the value of recording all near misses to help identify and monitor risk reduction actions. The monthly safety report included details of actions taken in response to adverse events. For example, the team clearly identified 'look-alike and sound-alike-medicines (LASA's) using warning labels on shelf edges. And the use of tall man lettering on these warning labels helped to further differentiate LASA medicines.

The pharmacy had a complaints procedure in place and it advertised how people could raise a concern or provide feedback through its website. Team members could describe how they would manage a concern and escalate it onto the RP, area manager or superintendent pharmacist (SI) if required. Team members provided examples of how they had used feedback to help inform the safe and efficient delivery of pharmacy services. For example, the team had implemented a red basket system to identify priority prescriptions such as acutes. This helped to ensure the medicines were ready by the cut-off time for the delivery. It also allowed the team to contact people if their prescription was received after the cut-off time to schedule the delivery. Or to make alternative arrangements if the prescription was urgent.

The pharmacy had up to date indemnity insurance arrangements in place. The RP notice was displayed clearly with the correct details of the RP provided. The RP record was maintained in accordance with requirements. The pharmacy maintained an electronic controlled drug (CD) register. Entries within the register were made in accordance with legal requirements. And regular balance checks between the register and stock took place. On average full balance checks varied between fortnightly and monthly. A physical balance check of a medicine chosen at random complied with the running balance in the register. The pharmacy generally maintained its specials records in accordance with the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). It supplied some quantities of a high-priced unlicensed medicine to other pharmacies within the company. These supplies were made in clearly labelled amber bottles and was in line with the pharmacy's registerable activities. A copy of the original certificate of conformity was sent to the pharmacy requesting the medicine. This ensured the dispensing pharmacy maintained an accurate record of the supply. But the hub team did not keep a record of the supplies made to other pharmacies on the original certificates of conformity. This meant it

could be more difficult to effectively trace a supply should a product recall or safety alert be raised.

Pharmacy team members had read and signed the pharmacy's information governance procedures. The review date on these procedures indicated they were due for review. Pharmacy and delivery team members had completed data protection training through e-learning modules. The pharmacy held all personal identifiable information within the registered premises prior to transferring assembled medicines to the delivery team, based in the warehouse. Only delivery personnel and pharmacy staff occupied this area of the warehouse. And there was no public access into the pharmacy or warehouse. The pharmacy had secure arrangements for disposing of its confidential waste.

The pharmacy had procedures to help support team members in identifying and reporting concerns about vulnerable adults and children. All pharmacy professionals had completed level two safeguarding training. And all pharmacy and delivery team members engaged in other safeguarding training. This included dementia awareness and mental health awareness training. Pharmacy team members demonstrated how they acted to help safeguard people. For example, there was evidence of interventions with GP surgeries recorded when prescriptions for higher risk medicines were received ahead of their scheduled dispensing dates. The pharmacy team provided an example of how it had worked with a care team to support the delivery of medicines to a vulnerable person. And the team was working through a request made during the inspection to support a vulnerable person. The pharmacy worked with organisations across the county to promote key messages to help keep people safe. This included some recent work with Lincolnshire police to raise awareness of fraud. And a current campaign on promoting awareness of modern slavery and exploitation. These messages were spread through the pharmacy sending information leaflets to people with their medicine delivery.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs suitably skilled team members to manage its workload. It monitors its workload and uses effective systems to ensure the team completes all tasks in a timely manner. The pharmacy promotes a clear culture of openness and honesty. Team members demonstrate enthusiasm for their roles and they engage in continual shared learning to inform the safe delivery of pharmacy services. There is a culture of mentoring through team members actively supporting the development of their colleagues. Pharmacy team members work well together and understand how to provide feedback and raise a professional concern if needed.

Inspector's evidence

The pharmacy employed a full-time pharmacist manager, two ACTs (one of which was the team leader), a pre-registration pharmacy technician currently going through the GPhC registration process, four qualified dispensers and a pharmacy student. Most team members worked full-time but there was some flexibility to support leave arrangements. And annual leave was well-planned and considered other absences and cover available. One team member was due to transfer to another of the company's pharmacies shortly. And this upcoming job vacancy was advertised. The pharmacy used a task rota which saw team members assigned to specific tasks in two hour blocks. For example, answering the phone, labelling, assembly, managing owings, and managing failed deliveries. The rota saw each team member rotate between different tasks. This meant that all team members had a good understanding of each part of the operation.

The pharmacy supported the learning and development of its team members. This included providing structured appraisals and managers engaging in regular one-to-one discussions with team members. The frequency of one-to-one discussions increased for team members in training roles. Team members skills and competencies were reviewed to support them in expanding their roles. For example, trainee dispensers did not handle some higher risk medicines. Once qualified they were supported in developing their role and became involved in supporting higher risk activity. Several team members described feeling well supported when completing training roles. And these roles varied between induction training and ACT training. The pharmacy provided protected learning time for all team members; this typically took place in an afternoon after the prescription cut-off time each day. The pharmacy maintained training records for its team members. And there was an emphasis on meeting the requirements of the NHS Pharmacy Quality Scheme. For example, the pharmacist was required to completed New Medicine Service consultations.

Most delivery team drivers had completed the necessary training for their roles. This included training associated with procedures and regular e-learning. One delivery driver had been employed in November 2020 and had not been enrolled on a GPhC accredited training course relevant to their role. This did not meet the GPhC's current training requirements for pharmacy support staff. This matter was acted on immediately following feedback to the SI. And evidence of enrolment on an accredited course was received by the inspector shortly after the inspection took place.

Team members demonstrated how they regularly shared learning and information through conversation. And details of these conversations were recorded within the monthly patient safety

review. Team members provided clear examples of how they were encouraged to support each other's learning and development. For example, the team leader acted as a mentor and expert witness to support the pre-registration pharmacy technician. A team member took the opportunity to demonstrate how a colleague helped to reduce the risk of picking and assembly errors by highlighting the drug formulation on a prescription form. And another team member demonstrated LASA posters which were positioned around the dispensary to help inform team members of the checks they could make to lower the risk of picking mistakes associated with these medicines.

The pharmacy had a whistle blowing policy. Team members understood they were able to report concerns to the team leader or manager in the first instance. And a team member spoken to at random confirmed they would feel confident in escalating a concern to the SI's team if needed. Team members were confident at expressing their ideas. And a team member explained that regular discussions took place to share ideas and to help inform change. For example, discussions around workload management and the suitable placement of warning stickers and tall man lettering across the dispensary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and well maintained. It offers a suitable environment for delivering the services it provides.

Inspector's evidence

The pharmacy website included the name, registration number and contact information for the pharmacy. It also advertised details of the company that owned the pharmacy and the superintendent pharmacist's name and registration number. The website also provided information about how to check the registration details of the pharmacy or superintendent pharmacist against the GPhC's registers.

The premises were secure against unauthorised access. Access was restricted to pharmacy team members and other key personnel. Other company employees knocked on the door if they required access. For example, when delivering the stock order. The premises consisted of a good size dispensary with a small staff kitchen area to one side. They were maintained to a good standard. The pharmacy was clean and members of the pharmacy team had access to hand washing facilities and hand sanitiser. Further hand sanitising units were located at the main entrance to the building, and at the pharmacy's entrance. The pharmacy was well lit and air conditioning ensured medicines were stored below 25 degrees Celsius.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services safely. It obtains its medicines from reputable sources. And it has good processes for ensuring it stores its medicines safely, securely and at the correct temperature. Its team members work in accordance with procedures and use effective audit trails to help answer any queries that may arise during the dispensing process. Pharmacy team members engage regularly with people accessing the pharmacy's services. But sometimes miss opportunities to record the support they provide to people taking higher risk medicines.

Inspector's evidence

People accessed the pharmacy's services through either the website, by email or by telephone. The pharmacy's website provided further information about how people could access its services remotely and the pharmacy's opening hours. It signposted people to information to support them in living well and managing health conditions. And the website included an A-Z medicine guide and support in finding an NHS service. The pharmacy did not offer for sale any General Sales List (GSL) or Pharmacy (P) medicines through its website.

Team members used suitably sized baskets throughout the dispensing process. This kept medicines with the correct prescription form. Key information to support a person centred approach to dispensing was recorded on people's medication records. For example, requests to send out medication to a married couple together in one delivery. The pharmacy had a process in place to identify higher risk medicines. And people on these medicines received regular monitoring calls from a pharmacist or team member under the supervision of the RP. Time to make these calls was factored into the working day. But the team did not always take the opportunity to record details of counselling and interventions made during these telephone calls within people's medication records. The RP was aware of the requirements of the valproate Pregnancy Prevention Programme (PPP). And the pharmacy had the necessary safety tools to comply with these requirements. For example, it had patient cards and guides to supply to people in the high-risk group. The pharmacy team couldn't recall supplying valproate to anybody within the high-risk group to date.

The pharmacy had an effective system for managing and monitoring medicines which it owed to people. This included telephoning people to discuss any potential delays in being able to supply a medicine because it was unavailable. And working with patients and their prescriber to consider alternatives when necessary. The owings process was built into the daily task management rota. The process was supported by an audit trail which ensured regular checks of longer-term medicine delays were monitored effectively. And specific information relating to the supply of the medicine was recorded on the prescription form. The pharmacy made regular stock supplies of medicines to a local NHS trust. It completed tasks associated with this activity through its MHRA Wholesale Distribution Authorisation for Human use (WDA(H)).

The delivery administration team regularly attended the pharmacy to collect assembled medicines for delivery. At this point the company's central delivery hub took control of the assembled bags of medicines. This included storing items safely whilst waiting for delivery and during transit. And ensuring medicines were stored at correct temperatures up until a delivery was made. The delivery administration team scheduled effective delivery routes using a computerised system to help support

efficiency. The delivery hub did not currently require people to sign for their medicines due to the pandemic. But it maintained effective audit trails to identify a delivery had been made. The pharmacy had not needed to send medicines outside of the geographical area covered by its delivery fleet to date. But it had procedures and packaging to support the safe delivery of medicines through a postal or courier service. A pharmacy team member was also designated to manage failed deliveries on a daily basis. This process included delivery drivers returning the medicine to the pharmacy if a person was not at home to receive it. And pharmacy team members monitored these failed deliveries and made relevant checks with people or carers to help establish why a delivery had failed. This allowed the pharmacy team to identify when the medicine could be redelivered or place a hold on the delivery if required. For example, when a person was admitted to hospital and the pharmacy required medicines discharge information prior to confirming that the medicine remained current.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Medicine storage in the dispensary was orderly with medicines stored in their original packaging. The pharmacy had secure cabinets to store medicines subject to safe custody regulation. Medicines inside the cabinets were stored in an orderly manner. And the pharmacy identified these medicines during the dispensing process to ensure additional legal and safety checks took place prior to delivery. The pharmacy stored medicines subject to cold chain requirements safely in a pharmaceutical refrigerator. It kept a fridge temperature record. The record indicated the fridge was operating between two and eight degrees Celsius as required. A team member demonstrated how additional temperature checks took place following date checking and cleaning tasks when the door needed to be left open for an extended length of time.

The pharmacy team followed a date checking matrix and it had a system for identifying and monitoring medicines with short expiry dates. Liquid medicines with shortened expiry dates once opened were clearly identified. A random check of dispensary stock found no out-of-date medicines on the dispensary shelves. Medicine waste bins were available as were CD denaturing kits. The pharmacy received medicine recalls and alerts electronically. And it maintained an audit trail of the checks it made in response to these alerts. The team also took the opportunity to discuss recent alerts during monthly patient safety reviews.

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 equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date written and electronic reference resources. For example, the British National Formulary (BNF) and BNF for Children. And they used the internet to help resolve queries and to obtain up-to-date information. The pharmacy protected its computer terminals from unauthorised use through the use of passwords and personal NHS smartcards.

The pharmacy team used crown stamped measuring cylinders for measuring liquid medicines. Equipment for counting capsules and tablets was also available. There was separate equipment available for counting and measuring higher risk medicines. This equipment was clearly identified and stored separately to reduce any risk of cross contamination. The pharmacy was subject to periodic health and safety checks. These checks included reviewing the equipment used to support the provision of pharmacy services.

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.