

Registered pharmacy inspection report

Pharmacy Name: East Midlands Pharmacy Lincoln, 15 Sincil Street,
Lincoln, Lincolnshire, LN5 7ET

Pharmacy reference: 9011420

Type of pharmacy: Community

Date of inspection: 20/03/2024

Pharmacy context

This community pharmacy is in a pedestrianised area of Lincoln City centre. Its main services include dispensing prescriptions and selling over-the-counter medicines. The pharmacy provides a good range of NHS and private services including the NHS England Pharmacy First service, NHS blood pressure check service, a private phlebotomy service and a private aesthetic service. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers some medicines to people's homes.

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	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

Overall, the pharmacy effectively identifies and manages the risks for providing its services. It keeps people's confidential information secure. And it mostly keeps the records it needs to by law. Its team members understand how to respond to feedback about the pharmacy and its services. And they have the knowledge and resources to recognise and report concerns to help protect vulnerable people. Pharmacy team members behave openly and honestly by engaging in discussions following the mistakes they make during the dispensing process to help make sure they learn from them.

Inspector's evidence

The pharmacy had changed ownership in November 2023. The superintendent pharmacist (SI) had implemented new standard operating procedures (SOPs) following this change of ownership. Pharmacy team members on duty stated they had read these, but the pharmacy did not have training records for this learning available for inspection. Team members were observed completing tasks safely and effectively throughout the inspection. And they appropriately referred queries to the SI, who was working as the responsible pharmacist (RP). A team member discussed the tasks they could not complete if the RP took absence from the pharmacy. And they explained their approach to managing requests for some higher-risk Pharmacy (P) medicines liable to abuse, this included referring repeat requests for these medicines to the pharmacist.

The SI demonstrated how they had considered the risks of introducing new services. For example, they had sought assurances about the aftercare process used by the healthcare provider the pharmacy conducted the blood testing service for. And they had assured themselves the pharmacy was sending bloods to a UKAS registered laboratory. The aesthetic service consisted of anti-wrinkle injections only. Information from one of UK's voluntary aesthetic regulators was available in the consultation room used solely for this service. The SI demonstrated their processes for managing risk when providing the service. This included training arrangements, mode of consultation and service delivery, storage of injections and storage of equipment for the service. But the SI had not taken the opportunity to record this information in a formal risk assessment. The pharmacy was a pilot site for using automated functions within its patient medication record (PMR) system. These functions allowed the RP to record clinical checks of prescriptions prior to the dispensing process starting. Team members then completed a series of checks using barcode technology during the assembly process and for the final accuracy check of the medicine. The pharmacy was in the initial stages of exploring how this technology would support it in managing its workload as services expanded. The pharmacy was joining the NHS Community Pharmacy Independent Prescribing Pathfinder Programme in the coming months.

The pharmacy had processes for managing mistakes its team members made and identified during the dispensing process, known as near misses. Following a mistake being identified, team members checked their work and corrected their mistake. They generally recorded their near misses and they acted to reduce risk by ensuring stock medicines were stored in an orderly manner within the dispensary. The team had not taken the opportunity to formally review its near miss records for patterns in mistakes to support ongoing shared learning and risk reduction actions. The pharmacy had an incident reporting procedure in the event a mistake was identified following the supply of a

medicine to a person, known as a dispensing incident. The SI provided evidence of incident reporting, these reports aimed to identify the root cause of a mistake and the actions taken to reduce the risk of a similar mistake occurring.

The pharmacy had a complaints procedure. But it did not advertise how people could provide feedback or raise a concern about the pharmacy. A team member provided examples of how they responded to feedback, and they knew to escalate a concern to the SI if needed. Most pharmacy team members had completed some learning to assist them in recognising and reporting safeguarding concerns. And they knew what to do if somebody attended the pharmacy wishing to access a safe space. The SI had completed level three safeguarding training. They had resources available to them to support them in reporting a concern. And they explained they would use the internet to find current contact information of safeguarding agencies. The pharmacy protected people's personal information by supervising access to its consultation spaces and restricting access to staff-only areas of the premises. It held confidential waste safely and disposed of this securely.

The pharmacy had current indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. And the RP record was completed in full. A sample of records made in the private prescription register found team members did not always enter the prescriber's details accurately when entering the supply of a medicine against a private prescription. The pharmacy maintained running balances in its controlled drug (CD) register. But it did not always complete page headers and it did not always enter the address of a wholesaler when recording the receipt of a CD in its register as required. It completed regular balance checks of physical stock against its register. A random physical balance check of a CD completed during the inspection matched the balance recorded in the CD register. The pharmacy held a record of the patient-returned CDs it received.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has an enthusiastic team of people who work well together to provides its services. Its team members engage in structured learning relevant to their roles. Pharmacy team members know how to provide feedback and raise concerns. And they have regular conversations to support them in delivering the pharmacy's services safely.

Inspector's evidence

The SI worked as the full-time pharmacist. Another of the company's directors was a trainee pharmacy technician and worked across the pharmacy's peak operating hours. The pharmacy also employed a trainee dispenser, two drivers and a new team member had recently started working at the pharmacy one day a week. The pharmacy also provided work placements for students studying pharmacy at the city's university. The pharmacy employed a locum pharmacist to support short periods of absence taken by the SI. And another locum pharmacist had completed some shifts alongside the SI to support them in understanding the pharmacy's processes prior to them providing cover for annual leave.

The trainee pharmacy technician and trainee dispenser felt supported in their learning roles. They were both enrolled on GPhC accredited learning courses. But the pharmacy had not enrolled its drivers on a GPhC accredited course relevant to their role as required. The SI took swift action to meet this requirement following the inspection. The new team member completed tasks for the multi-compartment compliance pack service only. They had received specific training for the tasks they completed. This team member had previously worked in care services and had completed learning for the safe handling and administration of medicines in their previous role. A discussion highlighted the need to enrol this team member on a GPhC accredited learning course within three months of starting their role. The SI had completed a range of training courses to support them in delivering the pharmacy's services safely. This included specific training for the aesthetic and phlebotomy services. They had achieved their independent prescribing qualification. And they were engaging in structured learning ahead of using this qualification to provide NHS prescribing services from the pharmacy.

The pharmacy had a whistleblowing policy and its team members understood how to raise a concern at work. They worked well together and were confident in providing feedback and suggesting ideas. For example, the trainee dispenser had suggested the pharmacy contact people by text message on the date of their delivery. This arrangement supported people in contacting the pharmacy ahead of the delivery if there were any issues with delivering on a specific date. Team members communicated with each other openly throughout the working day. And the directors used opportunities during the lunch time closure to discuss areas for focus within the pharmacy.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean, secure, and suitably maintained. It provides a modern and professional environment for delivering healthcare services. People visiting the pharmacy can speak with a pharmacy team member in confidence in a private consultation room.

Inspector's evidence

The premises were secure and generally kept in a good state of repair. There was one outstanding maintenance issue which the SI reported was in the process of being addressed. And some sandbags at the pharmacy's fire exit indicated there may be a risk of flooding. The SI explained these were used as a precaution in severe weather due to previous flooding of the premises. The pharmacy was clean and very well presented throughout. Lighting was bright and air conditioning kept an ambient environment for delivering pharmacy services. Pharmacy team members had access to hand washing facilities, including sinks in both consultation rooms. The consultation room sinks were not equipped with antibacterial hand wash. Hand sanitiser was readily available in both rooms.

The pharmacy was spread over two floors. On the ground floor there was a small open plan public area and access to two well-equipped consultation rooms. The first room provided a relaxed and professional environment for the pharmacy's aesthetics service. A high-specification medical chair was fitted in this room to support the pharmacist in administering anti-wrinkle treatments. The second consultation room was spacious and professional in appearance. The SI used this room to complete most of the pharmacy's consultation services. Both consultation rooms were secured by a touch free sensor lock system. The dispensary was a suitable size for the level of activity taking place with different areas used for labelling, assembling, and checking medicines. Team members had access to staff facilities on the first-floor level of the pharmacy. There was also ample storage space on this floor for items such as dispensary sundries, archived records, and medicine waste.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy promotes its services well and they are fully accessible to people. It obtains its medicines from reputable suppliers, and it stores its medicines safely and securely. Pharmacy team members use audit trails effectively to help manage dispensing services. And they provide some information when supplying medicines to help people take their medicine safely.

Inspector's evidence

People accessed the pharmacy from street level through an automatic door. The pharmacy clearly advertised its opening hours. A television screen in the pharmacy window advertised its services. The pharmacy had worked with the Local Pharmaceutical Committee (LPC) and the local NHS Integrated Care Board (ICB) by making videos to promote the NHS Pharmacy First Service. The videos showed people what to expect when visiting a pharmacy for some of the seven conditions they could treat through the service. It did this by role-playing the consultations within the pharmacy to help people understand how the service was provided. Pharmacy team members had good local knowledge of other pharmacies and healthcare services. They knew to signpost people to these organisations if they required a service or medicine the pharmacy could not provide.

The pharmacy protected P medicines from self-selection by displaying them behind the medicine counter. The SI had full supervision of the public area from the dispensary. The SI had access to appropriate information and resources to support them in providing the pharmacy's consultation services. This information included current patient group directions (PGDs) for the medicines supplied through the NHS Pharmacy First Service. The SI documented the consultations they had with people. They kept good records of the consultations they had with people accessing the aesthetics service. People accessing this service received three face-to-face consultations. The SI documented the person's medical history and proposed treatment plan within the first consultation. People returned to the pharmacy for a second appointment in which the treatment was administered following written consent. The SI recorded details of the treatment administered, including batch numbers and expiry dates of the injections during this consultation. People attended the pharmacy for a follow-up consultation with the SI to assess the success of the treatment. The SI recorded this follow-up consultation. The pharmacy gave people the option to have their blood pressure checked in either a consultation room or in the relaxed waiting area in the public area of the pharmacy, whichever a person preferred. The SI demonstrated positive outcomes from this service with people going on to start treatment for previously undiagnosed high blood pressure.

The pharmacy had some processes for identifying higher-risk medicines during the dispensing process. This included processes for applying additional checks when dispensing CDs and medicines requiring refrigerated storage. The SI discussed the requirements of the valproate Pregnancy Prevention Programme. And they explained the checks they would make if supplying valproate to a person in the at-risk group. But the pharmacy had not fully considered the recent legal update about the need to supply valproate in the manufacturer's original packaging as it had not completed risk assessments when supplying this medicine in a multi-compartment compliance pack. Shortly after the inspection, the SI provided assurances of a review taking place to support the pharmacy in fully complying with the legal changes.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form, and it helped the team manage workload priority. Pharmacy team members signed their initials in the 'dispensed by' and 'checked by' boxes on medicine labels. This provided a dispensing audit trail and helped to direct a query should one arise. The pharmacy kept a record of the medicines it owed to people, and team members made regular checks to help ensure it obtained these medicines in a timely manner. It informed prescribers of concerns about the availability of medicines. The pharmacy kept an audit trail of the medicine deliveries it made to people's homes. This helped it to answer any queries it received about this service. It recorded any specific delivery instructions required to support its team members in delivering medicines safely and effectively.

The pharmacy used individual records to support in supplying medicines in multi-compartment compliance packs. These records helped to identify changes to medicine regimens which the team checked with prescribers. A team member processed prescriptions for this service and they picked the stock ready to assemble the compliance packs. This stock was held in individual baskets with people's medication records and prescriptions. The new team member then checked each medicine against the record and prescription prior to beginning the assembly process. A sample of compliance packs examined were labelled clearly with descriptions of the medicines inside the compliance pack. But the pharmacy did not always supply patient information leaflets for the medicines it supplied in this way. It supplied these leaflets for new medicines or for people receiving their medicines in this way for the first time.

The pharmacy sourced medicines from licensed wholesalers. It stored medicines in an orderly manner within the manufacturer's original packaging. It held its CDs in a secure cabinet, and it held medicines requiring cold storage in a suitable fridge, equipped with a thermometer. The pharmacy kept temperature records for the fridge. But there were some gaps in these records. Temperature records either side of the gaps showed the fridge had remained within the required range of two and eight degrees Celsius. Team members recorded the expiry-date checks they made of the pharmacy's stock medicines. A random check of dispensary stock found no out-of-date medicines and most medicines with short shelf lives were clearly identifiable. Team members did not always annotate bottles of liquid medicines when opening them to show the opening date and details of any shortened expiry date. The pharmacy had appropriate medicine waste receptacles, CD denaturing kits and sharps bins available. It received medicine alerts through email, and it had a clear process for responding to these alerts.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely and effectively. Its team members use the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to the internet and a range of written reference resources. They used passwords and NHS smart cards when accessing people's medication records. The team stored bags of assembled medicines safely within the dispensary. This prevented people's personal information on bag labels and prescriptions from unauthorised view. The pharmacy had a cordless telephone handset. This allowed team members to walk out of earshot of the public area when discussing confidential information over the telephone.

The pharmacy had a wide range of equipment to support it in delivering its services. Team members had access to standardised counting and measuring equipment when dispensing medicines. Equipment to support the delivery of consultation services, including the NHS Pharmacy First Service was from recognised manufacturers and stored appropriately in the consultation room. Higher-risk equipment such as needles and equipment to support the phlebotomy service was stored in cabinets. The team had not considered the need for checking some of its equipment for expiry dates, such as the vacutainers it used for the phlebotomy service. Equipment checked during the inspection was within its shelf-life. And the SI acknowledged the need to apply regular checks to this equipment.

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.