Registered pharmacy inspection report

Pharmacy Name: Lincolnshire Co-Op Pharmacy, Central Fill Pharmacy, 5A Proctors Road, Lincoln, Lincolnshire, LN2 4LA

Pharmacy reference: 9012075

Type of pharmacy: Dispensing hub

Date of inspection: 22/05/2024

Pharmacy context

This is a hub pharmacy which assembles people's prescriptions in original manufacturers' packs for other pharmacies owned by the same company. The pharmacy delivers the assembled medicines to the other pharmacies for collection or delivery to people. People cannot access services directly from the pharmacy. It also supports with the delivery of the NHS New Medicine Service remotely from an office within the pharmacy.

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

The pharmacy uses a variety of methods to identify and manage risk for the services it provides. It keeps the appropriate legal records it needs to for the services it provides. The pharmacy keeps people's confidential information secure. And it has effective processes to share learning following mistakes both within the team and with other pharmacies involved. Pharmacy team members have defined roles and accountabilities and they work well within these roles.

Inspector's evidence

The pharmacy assembled original manufacturers' packs of repeat medicines as part of a 'hub and spoke' dispensing model. This model involved other pharmacies within the same ownership group (the spokes) sending prescription data through to this pharmacy (the hub) for assembly. Medicines were then delivered by the hub pharmacy back to spoke pharmacies ready for collection or delivery to people. The pharmacy used an automated system throughout the assembly process to support it in supplying medicines, which meant there were few manual assembly processes completed by team members. The pharmacy did not have any direct contact with the people who received the medicines it assembled. The company employed a best practice team made up of pharmacy technicians. This team was supporting the rollout of the service to spoke pharmacies and regularly fed back to the pharmacy's management team.

There were clear lines of accountability between the hub pharmacy and spoke pharmacies. The hub pharmacy was responsible for the accuracy of the medicine dispensed. The pharmacist at the spoke pharmacy, who had local knowledge of the patient and held the relationship with local prescribers retained the responsibility for the clinical check of prescriptions. This helped to ensure information, such as medication history was available to pharmacists carrying out clinical checks. And it supported local resolution of any queries. Pharmacy technicians and pharmacists at the spoke pharmacy also assumed responsibility for the data accuracy check of information sent to the hub pharmacy.

The pharmacy had core standard operating procedures (SOPs) to support its safe and effective running and pharmacy team members had completed learning of the SOPs relevant to their roles and responsibilities. Specific SOPs to support the specialised nature of the hub and spoke model were available in draft format. These had yet to be finalised and were not readily available to all team members. There was clear operational guidance available to all team members working within the hub pharmacy. And training records were available to confirm each operator and pharmacy team member had completed learning relevant to the tasks they completed. Individual team members competently demonstrated the tasks they undertook throughout the inspection process.

The pharmacy had initially concentrated its operations by working with another of the company's pharmacies located within the same warehouse building. This had supported the project manager and the initial project working group in trouble shooting problems with one pharmacy. And in working through a risk log of identified risks to support the development of the rollout. The rollout had been paused on several occasions throughout the initial stages of the project to resolve areas of concern. The pharmacy's risk log and a risk matrix provided further information about how the company had continually worked to identify and manage risk as it scaled up the service to 15 of its pharmacies to

date.

The pharmacy had processes for recording mistakes that occurred throughout the assembly process. The automated technology in use captured an electronic audit trail of who had completed each task. Each user was given a defined role and relevant tasks that were authorised to be completed for each role were coded into the technology. The use of the technology in this way prevented team members working outside of their defined roles. The pharmacy ran 'quarantine' reporting frequently to identify the interventions required throughout the assembly process. Quarantine reports identified an event at each stage of the assembly process that required a pharmacy-trained team member to intervene. This reporting helped the pharmacy to monitor risk and identify any learnings required. The pharmacy's team leader was an accuracy checking pharmacy technician (ACPT). All incidents were reported to the team leader, who recorded incidents via an electronic patient safety incident reporting system. There had been two significant incidents since the initial rollout of the technology around 11 months ago. The team leader demonstrated the learning that had been undertaken to prevent the recurrence of such incidents. The pharmacy notified RPs working in spoke pharmacies of any patient safety incidents involving tasks completed at the spoke pharmacies. This included reports due to inaccurate information being sent to the hub pharmacy, such as directions to 'take' inhalant medicines rather than 'inhale' a dose. And the reporting for these types of events was clearly linked to the spoke pharmacy on the incident reporting system. This encouraged the teams working at the spoke pharmacies to apply learning when both entering information and when completing data accuracy checks of the information being sent to the hub pharmacy.

The pharmacy had current indemnity insurance arrangements. It did not have a RP notice displayed as required as the inspection process began. The RP printed a notice and displayed this promptly. The RP and the area manager accepted this was an oversight and provided assurance that moving forward RPs would be reminded of the need to display a notice showing who the RP on duty was. The RP register was held in accordance with requirements and completed in full. There was no access by members of the public to the pharmacy. Access to the pharmacy's computer systems was password protected and confidential waste was disposed of securely. All team members completed mandatory information governance learning as part of the company's internal learning programme. The RP and ACPT had completed safeguarding learning to support them in their roles. The RP discussed how this learning was relevant when providing the NHS New Medicine Service (NMS).

Principle 2 - Staffing ✔ **Standards met**

Summary findings

The pharmacy has enough team members who work together well to provide the pharmacy's services. Team members complete bespoke training to support them working safely within their defined roles. They engage in conversations designed to support safe working practices. And they understand how to raise and escalate a concern at work.

Inspector's evidence

The pharmacy operated with company employed relief pharmacists in the RP role. All pharmacists received appropriate learning to support them in assuming the RP role when providing cover at the pharmacy. The RP was working alongside the team leader and a trainee dispenser. A number of operatives were trained to support the automated system assembly line with around six operatives on duty at any time. The pharmacy had considered the skill mix and tasks assigned to each team member. The automated system appropriately identified the role of the user, and only allowed pharmacy-trained users to complete certain tasks. The pharmacy had developed a bespoke training manual and a skill competency assessment to support the training requirements of its team members. But the pharmacy had yet to finalise this information within a roles and responsibilities matrix, currently only available in draft form. Another ACPT had undertaken some learning so they could support working in the pharmacy when the team leader took leave.

Team members worked well within the scope of their roles. The team leader completed regular observations of the activities undertaken by team members. And they were confident in reviewing quarantine reports to support ongoing learning. They also analysed patient safety reporting and addressed any learning required with the team through shared learning. The trainee dispenser felt supported in their learning role. They received training time at work. They also spent time in the company's other onsite pharmacy to gain a wider variety of experience and to support them with their learning and development. The RP felt no pressure to achieve a certain number of NMS consultations whilst working. They explained how they applied their professional judgement when providing these consultations and managing the input required with the assembly line. The pharmacy had a whistleblowing policy, and all team members had access to a confidential employee assistance support. Team members discussed feeling supported in their roles and knew how to raise and escalate concerns at work.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and appropriately maintained. Confidential telephone consultations are conducted in a suitably private area.

Inspector's evidence

The premises were located within the company's pharmacy head office and within the same warehouse as a wholesaler business and another registered pharmacy. The premises were clearly separated from other businesses operating within the building. Individual key cards provided assurance that only approved pharmacy team members and other key personnel had access to the warehouse and pharmacy. The premises consisted of a large open plan room fitted with the automated assembly line. There was some work bench space for completing administration tasks provided and plentiful space for holding stock orders coming into the pharmacy. The space was designed to support the expansion of the operation, so a second assembly line could be fitted at a later date if needed. There was also a small, enclosed office in the corner of this space. This was used by the RP when completing remote NMS consultations and it provided a protected space for holding private telephone conversations with people. The premises were maintained to a good standard, and they were appropriately clean. The pharmacy was well lit and temperature controlled.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services well, using automation and barcode technology. And it engages with spoke pharmacies effectively to support people in receiving their medicines in a timely manner. The pharmacy obtains its medicines from reputable sources. And its continual monitoring processes provide assurances that these medicines are safe to supply to people.

Inspector's evidence

People did not access the pharmacy directly, all contact for dispensing services was through the teams at the spoke pharmacies. Pharmacists carried out consultations with people who had received new medicines, on behalf of the company's local pharmacies. They used an online platform that gave access to all the NMS records of the company's pharmacies. The platform prioritised records, based on time elapsed since dispensing. The RP contacted the local pharmacy where people had their prescriptions dispensed at the beginning of the working day to set out their plan for support. This meant there was no risk of the RP working in the local pharmacy contacting a person on the same day. Pharmacists providing this service did not have access to a person's patient medication record (PMR). The RP identified how they would ask for permission to access a person's medical information through the National Care Record Service. They discussed how they would document the consultations, including any liaison with GP surgeries and prescribers. And they signposted people back to their local pharmacy if they needed a face-to-face consultation with a pharmacist.

The hub assembly process was limited to repeat prescriptions. The hub pharmacy received prescription data from the spoke pharmacies via software that was integrated with the electronic PMR at the spoke pharmacies. This meant that the RP at the hub pharmacy could see that the prescriptions had been clinically checked by the pharmacist at the spoke pharmacy. And the teams at the spoke pharmacies were able to track updates to a prescription's progress at each stage of the process. Spoke pharmacies also had the option to retrieve a submitted prescription and dispense it locally if required to ensure people received their medicines when they needed them. This process included contacting the hub pharmacy first, to ensure there was no risk of the same prescription being assembled twice. Data from prescriptions received up until 6pm at the hub pharmacy were processed, and the medicines returned in sealed bags to the spoke pharmacies the following working day.

The assembly process relied on automation and barcode technology to track each step. The pharmacy received the stock it needed from the adjoining wholesaler business. This was ordered using a picking list generated on the information provided by the spoke pharmacies. If a medicine was not available, or there were any concerns with the data received the pharmacy rejected the full prescription on its system, and it returned it back to the spoke pharmacy for local dispensing. The stock was transferred in bright wholesaler boxes clearly labelled for individual spoke pharmacies. Team members processed medicines for one pharmacy at a time by feeding this stock one-by-one onto a conveyor belt. The automated system then scanned barcodes on the stock for recognition. This mostly provided information unique to each medicine, such as its batch number and expiry date. This information linked to individual people's prescription items and allowed the system to produce and apply a dispensing label to the box, which was also barcoded. If it was unable to apply a label or identify a medicine an intervention was triggered, this required a response from a pharmacy trained team member. Team

members retrieved the labelled medicines at the other end of the conveyor. They scanned the barcode on the dispensing label of each medicine individually and using automation the team member was directed to put the medicine in a designated basket. Baskets were fitted with sensors so the system could track them on the numbered shelves. To ensure only one person's medicines were placed in a basket, the system illuminated a light above the basket on a shelf, in which to place the stock.

The system alerted team members if an intervention was required by a pharmacy trained team member through the use of an orange light above the basket. There was no way of operatives overwriting the need for an intervention as pharmacy professionals were required to log-in to complete these interventions. Once all medicines were assembled in a basket the light above the basket changed to green, and the basket was moved to numbered shelves in an area where the medicines were put into bags and sealed. The system required an accuracy check by the RP or ACPT on a proportion of the orders processed or on those placed into quarantine, such as items too large for the automated labeller and items newly added to the system's database. The packing process required the operator to scan the basket containing a completed order to produce a barcoded bag. The barcode on the bag was scanned, and each labelled product was scanned again before being placed into the bag. This was repeated until the order was complete. The bag was then sealed, and the bag was scanned along with the box it was being placed into ready for delivery to the spoke pharmacy. Boxes containing assembled bags of medicines were securely closed and transferred to the onsite warehouse for delivery out to the spoke pharmacies. Delivery to the spoke pharmacies was completed by company employed delivery drivers.

Dispensing labels had the hub pharmacy's details on and wording to show which spoke pharmacy it had been assembled on behalf of. The sealed bag also contained this same information. A discussion about the valproate Pregnancy Prevention Programme during the inspection identified that team members did not always consider the orientation in which they placed a box of medicine on the conveyor in relation to where the dispensing label would be applied. This meant that there may be potential for a dispensing label to cover important safety warnings on a box of medicine. The pharmacy's management team provided assurances that this matter would be addressed. The company's processes required spoke pharmacies to provide counselling and relevant safety checks prior to handing out higher-risk medicines, including valproate.

The pharmacy did not hold its own stock of medicines. All stock was supplied by the onsite wholesaler and the wholesalers own date checking processes were used to support the safe supply of medicines to people. The pharmacy's automated processes meant batch number and expiry date were recorded. The system identified medicines it noted were nearing their expiry date and quarantined these for a manual check by a pharmacy professional. The pharmacy treated higher-risk medicines, particularly schedule 3 and 4 controlled drugs with care. These were manually checked upon receipt from the wholesaler and an audit trail of this activity was maintained as part of the pharmacy's safety processes. The pharmacy received medicine alerts and drug recalls electronically and demonstrated checks made in response to recent alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the equipment and facilities it requires to provide its services safely. It appropriately maintains its equipment and it has suitable service arrangements to support it in ensuring its equipment remains fit for purpose.

Inspector's evidence

The pharmacy's automated system was serviced and maintained by the systems manufacturer, who also conducted routine servicing of the equipment on a regular basis. There was a service support desk available for technical difficulties when needed. The team reported that all calls for assistance had been responded to well within the service agreement between the manufacturer and the pharmacy, and often within 20 minutes. The team documented any issues that occurred and fed this information back to the manufacturer.

The pharmacy computers were password protected. It had a good supply of baskets fitted with sensors to support the high throughput of the assembly process. And it had scanning equipment and spare batteries needed to maintain productivity throughout the day. There was also a back of generator to support the pharmacy in functioning in the event of a power cut and backup arrangements to support connection to the internet.

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.