General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 235-237 Church Road, Redfield, BRISTOL, Avon, BS5 9HL

Pharmacy reference: 1028604

Type of pharmacy: Community

Date of inspection: 29/09/2020

Pharmacy context

This is a community pharmacy in the eastern suburbs of the city of Bristol. A wide variety of people use the pharmacy but most are elderly. The pharmacy team members dispense prescriptions, sell over-the-counter medicines and give advice. They also supply many medicines in multi-compartment compliance packs to help vulnerable people in their own homes to take their medicines. The pharmacy offers Medicines Use Reviews (MURs), the New Medicine Service (NMS), the Community Pharmacy Consultation Service (CPCS), seasonal flu vaccinations and several other services. The inspection was carried out during the COVID-19 pandemic.

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's working practices are generally safe and effective. It has made changes to its written procedures as a result of COVID-19. And, some physical measures are in place to reduce the risk of transmission of coronavirus. The pharmacy is appropriately insured to protect people if things go wrong. It keeps the required records. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people. But they could be better at recording and learning from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team members generally identified and managed the risks associated with providing its services. They had put some physical changes in place, as a result of the COVID-19 pandemic, to reduce the risk of transmission of coronavirus (see under principle 5). The pharmacy had updated its standard operating procedures (SOPs) with changes relating to the pandemic. But the team members were not adhering to the new SOP for accepting patient-returned medicines during the pandemic. The manager gave assurances that he would get all the staff to read and sign all the new SOPs. The pharmacy had updated its business continuity plan to accommodate any potential issues relating to the current NHS 'test and trace' scheme. However, the manager was not sure of the details to ensure that there was no disruption in the supply of medicines to their patients if the pharmacy had to close. The manager had conducted risk assessments of the premises and occupational risk assessments of all the staff. The team members were asked about any potentially vulnerable people in their households and also about their mental health. The manager regularly reviewed the risk assessments. The pharmacy team members were aware that they needed to report any COVID-19 positive test results.

The pharmacy team members did not record all near miss mistakes, that is, mistakes that were detected before they had left the premises. Those that were recorded did not include any learning points or actions to prevent future recurrences. The near miss log was said to be reviewed each month but the latest review could not be located at the time of the visit.

The main dispensary was tidy and organised. There were dedicated working areas, including a clear checking area. At the back of the main dispensary, there was a separate area where the multi-compartment compliance pack prescriptions were processed. There was a spacious separate room where the dispensary team assembled and checked the compliance packs. The dispensary team members placed the prescriptions and their accompanying medicines into baskets. This reduced the risk of errors. They used coloured baskets for different prescriptions and this allowed the pharmacist to prioritise the workload.

The pharmacy team members understood their roles and responsibilities. A medicine counter assistant was seen to ask the pharmacist about the suitability of a herbal sleep remedy for a person. All the staff knew that codeine-containing medicines should only be sold for three days use and they would refer any multiple sale requests for painkillers, to the pharmacist.

The team was clear about the pharmacy's complaints procedure. The manager said that some people had complained, early on in the pandemic, about waiting times. But now, most people were patient

and understanding.

The pharmacy had current public liability and indemnity insurance provided by the National Pharmacy Association (NPA). It kept the required up-to-date records: the responsible pharmacist (RP) log, controlled drug (CD) records, private prescription records, emergency supply records and specials records. The pharmacy also had fridge temperature records, date checking records, patient-returned CD records and cleaning rotas.

All the staff understood the importance of keeping people's private information safe. They stored all confidential information securely. The computers, which were not visible to the customers, were password protected. The correct NHS smartcards were seen in the appropriate computers. The pharmacy had its confidential wastepaper information collected for appropriate disposal. The pharmacy offered face-to-face services. These were done in the consultation room. People could not be overheard or seen in the consultation room.

The pharmacy team understood safeguarding issues. The pharmacist sen, a locum, had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. The pharmacy had local telephone numbers to escalate any concerns relating to both children and adults.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy currently has enough staff to manage their workload safely. The team members do their best to cover people who are sick or on holiday. They are encouraged to keep their skills and knowledge up to date. And they are told about any updates regarding COVID-19. But the team members could be better informed by the higher management about current and proposed changes.

Inspector's evidence

The pharmacy's current staffing profile was: one pharmacist, three full-time NVQ2 qualified dispensers, one of whom was the manager, one part-time NVQ2 trained dispenser, five part-time medicine counter assistants (MCAs) and two part-time delivery drivers. Up until the week before the visit, the pharmacy had a part-time accuracy checking technician (ACT), who worked at the branch for two days each week. The dispenser working in the compliance pack room did not know that the ACT was no longer going to be working at the branch.

The pharmacy assembled many medicines into compliance packs for domiciliary people. Several of these were currently dispensed off-site. The manager believed that this was planned to stop soon. He did not know the timescale or whether the pharmacy would receive additional staff in order to accommodate the increased workload. On the day of the inspection, eight compliance packs needed to be checked for collection or delivery the next day. The manager said that the branch had lost about 50 staff hours in the recent past. The removal of the ACT from the branch was said to be a trial. On 30 September 2020, the regional manager gave assurances that he would closely monitor the situation. It the branch fell behind with their workload, he would ensure that they received the appropriate ACT help.

The pharmacy only had one part-time dispenser. This meant there was limited flexibility to cover both planned and unplanned absences. In the event of planned leave, the dispensary team members tried to get ahead with their workload. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time.

The manager monitored the performance of the team members. They had an annual appraisal with a six-monthly review where any learning needs could be identified. The pharmacy team had monthly staff meetings. Any part-time members not present were updated via WhatsApp. The staff said that they felt able to raise any issues or concerns with the manager and that these would be acted on. But they were not able to give an example of any recent change as a result of their feedback.

The staff were encouraged with learning and development and completed regular e-learning, such as recently on the delivery of medicines. The team members were told about updates and advice regarding COVID-19. The pharmacist seen, a locum, documented all learning on his continuing professional development (CPD) records.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional and is suitable for the services it offers. It is clean, tidy and organised. The premises are thoroughly cleaned to reduce the likelihood of transmission of coronavirus. The pharmacy signposts its consultation room and so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The premises presented a professional image. Both the retail and the dispensing areas were spacious, tidy and organised. The dispensing benches were uncluttered and the floors were clear. The premises were clean. As a result of COVID, the premises were thoroughly cleaned every day. The hard surfaces were said to be wiped over more frequently than this. But there had been no formal changes to the cleaning rota to reflect this.

The consultation room was well signposted. People could not be seen or overheard in the consultation room. The pharmacy's computer screens were not visible to customers. The telephone was cordless and the staff took all sensitive calls out of earshot.

The temperature in the pharmacy was below 25 degrees Celsius and it was well lit.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a good range of services and everyone can access them. It generally manages its services effectively to make sure that they are delivered safely. The team members usually make sure that people have the information they need to use their medicines properly. But they could be better at identifying people who may not be taking their medicines as prescribed by their doctors. The pharmacy gets its medicines from appropriate sources and stores them safely. The team members makes sure that people only get medicines or devices that are safe.

Inspector's evidence

Everyone could access the pharmacy and the consultation room. The pharmacy team members could access an electronic translation application for any non-English speakers. The team members could print large labels for sight-impaired people.

The pharmacy was located in the eastern suburbs of the city of Bristol. Most of its prescriptions were electronically transferred from local surgeries and most were for local residents. Several compliance packs and many regular repeat prescriptions were currently dispensed off-site. The pharmacist clinically checked the prescriptions prior to this. And there was an audit trail demonstrating that this was done. The dispensary staff initialled the 'dispensed by' and 'checked by' boxes on the labels of all items dispensed at the pharmacy. This provided a clear audit trail of the dispensing process.

In addition to the essential NHS services, the pharmacy offered several additional services: Medicines Use Reviews (MURs), New Medicine Service (NMS), the NHS emergency hormonal contraception (EHC) service, the Community Pharmacy Consultation Service (CPCS) and the seasonal flu vaccination service (NHS and private). It also offered private services against local protocols: detection and treatment of urinary tract infections, supply of chloramphenicol for the treatment of bacterial conjunctivitis in children under two, the use of hydrocortisone on the face and the treatment of impetigo. The regular pharmacist (not seen) had completed suitable training to provide all these services.

The regular pharmacist and accredited locums were providing flu vaccinations. The NHS in the south-west had funded a new electronic means of pre-populating the pre-assessment form for the vaccinations, PreConsult. The application allowed the form to be pre-populated ahead of the pharmacist consultation. PreConsult could be used in two different ways. Patients could scan a QR code (a two-dimensional version of a barcode made up of black and white pixel patterns), on their own smartphone and enter their own information. Or, the pharmacy team members could enter the patient information, in the pharmacy or during a telephone booking. By reducing the pharmacist/patient contact time, PreConsult helped to reduce the infection risk and to increase the capacity of the pharmacy to deliver larger number of vaccinations. The Avon Local Pharmaceutical Committee had provided a webinar on PreConsult and also advice about the use of personal protective equipment (PPE). Pharmacists were advised to wear type 2 fluid resistant masks and face shields for sessional use. The pharmacist seen, a locum, was not accredited to provide flu vaccinations.

The manager said that people booked appointments for the flu vaccine online or in the branch. The appointment slots were 15 minutes apart. The manager said that this was enough time to clean the consultation room after each vaccination. There had been some recent issues with the appointment

booking process and this had resulted in some delays and extra work. The process had since been updated. The pharmacy was however running short of vaccine for people over 65.

The pharmacy had several substance misuse clients who usually had their medicines supervised. Due to COVID-19, most of these clients now collected their medicines. A few were still supervised. This took place in the consultation room. The client disposed of the container themselves into a dedicated basket. The supervising pharmacist washed their hands after the supervision. The locum seen did not know if the pharmacy recorded any concerns about these clients. Or, if it had their key worker telephone numbers in the event of an issue being identified outside of the service provider's normal office hours.

The pharmacy had many domiciliary people who had their medicines assembled into compliance packs. Some of these were currently dispensed off-site. The dispensing staff recorded any changes in dose or other issues. Those packs assembled at the pharmacy were done in a spacious separate room. The pharmacist doing the final accuracy check of these packs, referred to the recorded changes ot other issues. The assembled packs were stored tidily. The dispensing staff did not know if the regular pharmacist had done risk assessments of the people who had their medicines in compliance packs to see if anyone could have their medicines supplied in original packs.

The dispensary team highlighted any prescriptions containing potential drug interactions, changes in dose or new drugs to the pharmacist. But this was done verbally, and so, if the pharmacist was not available at the time, these many not be passed on. The pharmacy had several people who used the pharmacy's managed repeat prescription service. The pharmacy team did ask these people, when they collected their medicines, if the assembled medicines were what they were expecting. But, if a person did not want a particular item, they were not routinely referred to the pharmacist to ascertain the reason. This meant that some non-adherence or other concerns may go undetected.

The locum pharmacist seen routinely counselled people prescribed high-risk drugs such as warfarin and lithium and also those prescribed antibiotics or oral steroids. All pharmacy team members were aware of the pregnancy protection programme regarding sodium valproate. The pharmacy currently had no 'at risk' patients who were prescribed sodium valproate.

The pharmacy delivered several medicines to people. Because of the pandemic, the delivery drivers did not currently ask people to sign for their medicines to indicate that they had received them safely. They knocked or rang the doorbell and left the medicines on the doorstep. The drivers retreated and waited until the medicines had been taken safely inside. They annotated the delivery sheets accordingly.

The pharmacy got its medicines from AAH and Alliance Healthcare. Invoices for all these suppliers were available. It stored its CDs tidily in accordance with the regulations and access to the cabinets was appropriate. However, the pharmacy had many out-of-date CDs and patient-returned CDs. These were occupying one whole cabinet. Appropriate CD destruction kits were on the premises. The pharmacy stored its fridge lines correctly and it had date checking procedures. The pharmacy team members were accepting patient-returned medicines. But at the time of the visit, they were not adhering to the new COVID-related SOP for accepting these. There was an open tray in the dispensary containing several patient-returned medicines. The manager gave assurances that all the team members would be trained on the new SOP. The team members placed any medicines, considered hazardous for waste purposes, into a separate dedicated waste bin.

The pharmacy had procedures for dealing with concerns about medicines and medical devices. The pharmacy received drug alerts electronically. They were printed off and the stock was checked. The pharmacy had received an alert on 8 September 2020 about amlodipine 10mg tablets. It had none of

the affected batches in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy mainly has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose. The pharmacy has taken some action to reduce the spread of coronavirus with the use of protective screens. But the screens are small with gaps between them. This may increase the risk of transmission of the disease.

Inspector's evidence

The manager had done a risk assessment of the premises as a result of the COVID-19 pandemic. To reduce the risk of transmission of the disease, the pharmacy had erected two Perspex screens. But these were small and did not cover the entire medicine counter. There were large gaps between them. This increased the risk of transmission of coronavirus. In addition, at the start of the visit, not all the staff were wearing Type 2R fluid-resistant face masks and they could not remain two metres apart from one another all the time. The manager said that people-facing staff did routinely wear a mask. One staff member did not realise that wearing a face mask reduced the risk of her passing on the virus to other people. On 30 September 2020, the regional manager gave assurances that he would speak to all the team members. He will explain the reasoning behind the current government advice for all pharmacy team members to a wear Type 2 fluid-resistant face mask if they cannot remain two metres apart from one another at all times.

The pharmacy had placed some foot marks on the floor, two metres apart, indicating where people should stand. But there were no clear directions telling people how they should negotiate their way around the pharmacy. There was ample space in the retail area of the pharmacy to create a clear one-way flow of people.

The pharmacy used British Standard crown-stamped conical or ISO marked straight measures. There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. The pharmacy had up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children’s BNF. The staff could access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and the staff took any sensitive calls out of earshot. The pharmacy had its confidential waste information collected for appropriate disposal.

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.