General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 135-137 Church Road, Bishopsworth, BRISTOL, Avon, BS13 8JZ

Pharmacy reference: 1028607

Type of pharmacy: Community

Date of inspection: 22/01/2020

Pharmacy context

This is a community pharmacy in a shopping area in Bishopsworth, a suburb to the south west of the city of Bristol. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines. It also supplies several medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	The company has failed to put adequate procedures in place to accommodate a predicted large increase in workload at the pharmacy following the closure of a nearby branch.
2. Staff	Standards not all met	2.5	Standard not met	There is evidence that inadequate support is given by the company to accommodate the large increase in the pharmacy's workload following the closure of a nearby branch.
3. Premises	Standards not all met	3.1	Standard not met	Most parts of the pharmacy are cluttered and some areas, such as the consultation room are not clean. This does not present a professional pharmacy image and also increases the likelihood or mistakes.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not store all its medicines safely, including controlled medicines requiring special storage. This increases the risk of mistakes. And, it does not dispose of some specialist medicines safely.
5. Equipment and facilities	Standards not all met	5.1	Standard not met	The pharmacy does not have the appropriate facilities for its current substance misuse services.

Principle 1 - Governance **Standards not all met**

Summary findings

The company has failed to put adequate procedures in place to accommodate a predicted large increase in workload at the pharmacy following the closure of a nearby branch. This places the team members under pressure and, only after intervention by the inspector, have some services been transferred to another branch. This should ease the situation. In addition, the pharmacy can give little assurance that all mistakes are being recorded. And, there is no evidence to support that the team members are learning from these to prevent them from happening again. The pharmacy is appropriately insured to protect people if things go wrong. It keeps the up-to-date records that it must by law. The team members keep people's private information safe and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy team identified and managed some risks. But, on the day of the visit, all the dispensing areas were disorganised and cluttered. There were many baskets, stored on top of one another waiting to be checked. This increased the likelihood of errors. There was virtually no clear space for the assembly and checking of prescriptions. The manager reported that the workload at the pharmacy had increased greatly because of the closure of a nearby branch. She said that the number of items dispensed at the pharmacy had doubled and the number of supervised substance misuse patients had quadrupled (see further under principle 4). The pharmacy also now had a large number of multi-compartment compliance aid patients. The staff said that they were about two days behind with their normal work schedule. During the visit, the inspector telephoned the regional manager. The cluster manager arrived at the pharmacy shortly afterwards and reported that all the compliance aids would be transferred to another branch in the very near future. In addition to the cluttered dispensing areas, all the other areas included boxes of stock, including dispensary stock from the closed branch. This branch had ceased trading in August 2019. The pharmacy had been given some extra staff but only four months after the closure of the nearby branch.

The pharmacy was also not making any use of the company's off-site dispensing hub which may have eased the pressure due to the increased workload. In addition, new procedures for the storage of assembled prescriptions, according to the date that the labels were generated, was said by all the staff to be inefficient. Empty shelves, for the storage of assembled medicines, were seen whilst, several boxes of these, to be put away, were seen to be stored on the floor. Staff were seen to have to look through these boxes in order to locate the medicines for people who had come in to collect them.

Dispensing errors and incidents were said to be recorded. The staff said that the last error was a few months ago, but no one could recall any details, learning points or actions taken to prevent a recurrence. Near misses were said to be recorded but only the entries for January 2020 could be located during the visit. And, there were very few entries. This did not give assurance that all near misses were being recorded. Those that were documented, had no learning points or actions taken to reduce the likelihood of similar recurrences, such a recent error where picked quetiapine 150mg was past the expiry date. The staff said that the near miss log was not discussed with them. Only three incidents had been reported to the NHS England Accountable Officer since March 2018. These all involved discrepancies with morphine. No methadone errors had been reported which is surprising considering the large volume dispensed by the pharmacy, particularly of late. The staff were not aware

of professional standards bulletins from company's Superintendent's Office.

Coloured baskets were used and distinguished prescriptions for patients who were waiting, those calling back, those for collection and those for delivery. There was a clear audit trail of the dispensing process and all the 'dispensed by' and 'checked by' boxes on the labels examined had been initialled.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were continually reviewed every two years, or sooner, if necessary, by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. The company's sales protocol was not displayed as is customary throughout the company. The person serving on the counter was a medicine counter assistant trainee and she said that a displayed protocol would be useful. Only one member of staff was aware of the NFA-VPS (non-food animal, veterinarian, pharmacist, suitably qualified person) status of veterinary medicines. The pharmacy did sell these.

The staff knew about complaints procedure and reported that feedback on concerns was encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, 95% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. But, the manager said that this was done prior to the large increase in workload at the pharmacy. She said that most complaints were now about waiting times to be served.

Current public liability and indemnity insurance was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were in order. The date checking records were behind schedule, and as mentioned above, out-of-date quetiapine 150mg was found in the dispensary drawers.

An information governance procedure was in place and the staff had completed training on the general data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had read the company's procedures for the safeguarding of children and vulnerable adults. The pharmacist and technician had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing **Standards not all met**

Summary findings

At the time of the visit, the pharmacy was behind with their workload, indicating that it currently did not have enough staff to manage its workload safely. But, some services have subsequently been transferred to another branch. This should ease this situation. However, there is evidence that inadequate support is given by the company to accommodate the large increase in the pharmacy's workload following the closure of a nearby branch. And, staff undergoing training are not allocated any time for their courses so these may take longer than anticipated. They may also not be getting the support and help they need to complete the courses.

Inspector's evidence

The pharmacy was busy and in a shopping area in Bishopsworth, a suburb to the south west of the city of Bristol. They mainly dispensed NHS prescription items. At the time of the inspection, several domiciliary patients received their medicines in compliance aids. As a result of the visit, these had now been transferred to another branch for assembly and checking but were sent back to the branch for collection. Many substance misuse patients had their medicines supervised.

The current staffing profile was one pharmacist, one part-time accuracy checking technician (ACT) (one day a week), three full-time NVQ2 qualified dispensers (one of whom was the manager), one part-time NVQ2 qualified dispenser, one full-time medicine counter assistant (MCA) trainee and one part-time MCA. The pharmacy's workload had increased dramatically since August 2019 (see under principle 1). The manager said that extra hours had been provided but only four months later. They were currently two days behind with their work schedule and it was seen that many prescriptions were waiting to be checked indicating insufficient pharmacist or ACT hours.

There was limited flexibility for staff to cover unplanned absences. There was just one part-time qualified dispenser. There were some relief dispensers in the area and some unplanned absences were covered by them. Planned leave was said to booked well in advance. However, the regular pharmacist (not seen) was currently on four weeks annual leave. The staff said that this extended leave had put them under pressure. The manager was due to go on planned extended leave and the staff were not sure if her time off had been covered. The manager said that she had frequently asked for double pharmacist cover to accommodate the increase in workload as a result of the closure of the nearby branch but this had not been provided. On the day of the visit, the ACT was seen to be putting stock away, because the pharmacist, a relief, had not had time to clinically check the prescriptions so that she could do the final accuracy check. The ACT was said to be sometimes replaced with another ACT when she was on holiday but not always. There was rarely any second pharmacist cover. A partially assembled compliance aid was seen to be left because the dispenser was called to other duties. This increased the likelihood of errors. The staff said that they were not currently allowed to work overtime in order for them to keep on top of their workload. They said that they were about two days behind with their work schedule. A supervisor from another branch was working at the pharmacy on the day of the visit. She said that this was the case because the pharmacy was behind with their date checking.

The staff had an annual performance appraisal with a six-monthly review where any learning needs could be identified. The staff were encouraged with learning and development and completed e-Learning. They spent about 20 minutes each month of protected time learning. But, staff enrolled on

accredited courses, such as the MCA course, were not allocated any dedicated learning time. The GPhC registrants reported that all learning was documented on their continuing professional development (CPD) records.

There were no regular staff meetings and as mentioned under principle 1, the near miss log, errors or other incidents were not discussed with the staff. The manager said that she would implement monthly staff meetings. The pharmacist, a relief pharmacist, said that he was not set any specific targets, but tried to do two Medicines Use Reviews (MURs) each day.

Principle 3 - Premises **Standards not all met**

Summary findings

Most parts of the pharmacy are cluttered and some areas, such as the consultation room are not clean. This does not present a professional pharmacy image and also increases the likelihood of mistakes. The pharmacy signposts its consultation room so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was well laid out but all areas were untidy, disorganised and cluttered. Some areas, including the consultation room, needed cleaning. This did not present a professional pharmacy image. There was insufficient work space for the preparation of compliance aids, but these had been transferred to another branch following intervention by the inspector on the day of the visit.

The consultation room was relatively small and the door opened inwards which further compromised the space. And, access by the emergency services would be hampered if someone had to be placed in the recovery position on the floor. The pharmacy did offer seasonal flu vaccinations and so this was a possibility. The room had a computer, a stool and a chair but no sink. Conversations in the consultation room could not be overheard. The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

The temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not store all its medicines safely, including controlled medicines requiring special storage. This increases the risk of mistakes. And, it does not dispose of some specialist medicines safely. The team members generally make sure that people have the information that they need to take their medicines properly. But, they could be better at identifying any concerns about people who may not be taking their medicines as prescribed by their doctors.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but no bell on the front door alerting staff to anyone who may need assistance entering the pharmacy. The staff could access an electronic translation application for use by non-English speakers but they were unsure if they could print large labels for sight-impaired patients. A portable hearing loop was available.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), supervised consumption of methadone and buprenorphine, emergency hormonal contraception (EHC), Community Pharmacy Consultation Service (CPCS) and seasonal flu vaccinations. The latter was also provided under a private scheme as was blood pressure and glucose monitoring. The staff were aware of the services offered.

The pharmacist seen, a relief pharmacist, had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. He had also completed suitable training for the provision of the free NHS EHC service.

Many substance misuse patients had their medicines supervised and a few others collected their medicines. The numbers of these patients had quadrupled since a nearby branch had closed in August 2019. The medicines were assembled in advance with a manual pump. They were not stored safely. And, the pharmacist seen was not aware of the current shared care guidelines, The Recovery Orientated Alcohol and Drug Service (ROADS) guidelines. The inspector sent these. The pharmacist seen said that he would record any concerns about these patients on their electronic prescription medication record. The staff were not sure if the regular pharmacist recorded any concerns. There was a dedicated folder for the prescriptions for these patients but the telephone numbers of key workers were not available. The pharmacy was open for longer hours than the service provider and so these numbers would be useful. The pharmacist seen said that he offered the patients water or engaged them in conversation to reduce the likelihood of diversion.

Several domiciliary patients received their medicines in compliance aids at the time of the inspection but, these were due to be re-located to another branch for assembly and checking and then delivered back to the branch for collection by the patient or their carer. The pharmacy made sure that all patients who had their medicines in compliance aids and were prescribed high-risk drugs, were having the required blood tests.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. The pharmacist seen said that he routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. He asked about international normalised ratios (INR). The pharmacist also counselled patients prescribed amongst others, antibiotics, new drugs and

any changes. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. The staff were aware of the sodium valproate guidance relating to the pregnancy protection programme but were not sure if they had done an audit to identify 'at risk' patients.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Suitable patients were encouraged to use the company's managed repeat prescription service to reduce wastage, to optimise the use of medicines and to identify any non-adherence concerns. But, anyone not wanting a particular item was not routinely referred to the pharmacist and so potential non-adherence concerns may not be identified.

Medicines and medical devices were obtained from AAH and Alliance Healthcare. Specials were obtained from AAH Specials. Invoices for all these suppliers were available. CDs, particularly assembled methadone and buprenorphine was not stored safely. Access to the cabinets was appropriate. There were some patient-returned CDs according to the records but the cabinets were so full of assembled methadone and buprenorphine that it was difficult to find these. Similarly, this was the case with any out-of-date CDs. Appropriate destruction kits were on the premises. There were many totes of other medicines, including prescription only medicines, from the branch that had closed, stored in all areas of the pharmacy. Fridge lines were correctly stored with signed records. Date checking procedures were in place but, behind schedule, with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was no separate bin for cytotoxic and cytostatic substances or a list of such substances that should be treated as hazardous for waste purposes. Most staff did not know that all preparations containing the sex hormones were treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 22 November 2019 about ranitidine tablets. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

The pharmacy does not have the appropriate facilities for its current substance misuse services.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 50ml) and ISO stamped straight measures (10 - 100ml). There were several tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was limited access to the internet.

There were insufficient storage facilities and inadequate assembly facilities for the quantity of supervised methadone and buprenorphine patients. The fridge was in good working order and maximum and minimum temperatures were recorded daily. The blood pressure monitor was replaced every two years and the blood glucose machine was calibrated very 13 weeks.

The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive call were taken in the consultation room or out of earshot. Confidential waste information was collected for appropriate disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.