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: 28/09/2020

Pharmacy context

This is a community pharmacy in a shopping area in the south-western suburb of the city of Bristol. A wide variety of people use the pharmacy. The pharmacy team members dispense prescriptions, sell over-the-counter medicines and give advice. They also supply some medicines in multi-compartment compliance packs to help vulnerable people in their own homes to take their medicines. The pharmacy offers several services including Medicines Use Reviews (MURs), the New Medicine Service (NMS), the Community Pharmacy Consultation Service (CPCS) and seasonal flu vaccinations. This inspection was carried out 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	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 safe and effective. It has made changes to its written procedures as a result of COVID-19. And, 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.

Inspector's evidence

The pharmacy team members 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. It had also updated its business continuity plan to accommodate any potential issues relating to the current NHS 'test and trace' scheme. But the team members were unsure about specific details relating to them to make sure that their patients got their medicines if the pharmacy had to close. The manager said that she would find out about this. She had done a risk assessment of the premises related to COVID-19. All the team members had also completed an electronic occupational risk assessment. They were asked about potentially vulnerable people in their households. To date, the risk assessments had not been reviewed. The pharmacy team members were aware that they needed to report any COVID-19 positive test results.

The pharmacy team members recorded near miss mistakes, that is, mistakes that were detected before they had left the premises. They documented some learning points, such as, the similar packaging of Zapain and generic co-codamol 30/500 but they recorded few actions to prevent future recurrences. However, in July 2020 most of the mistakes had been identified as form errors. And, because of this, the staff now circled the form both on the prescription and on the label to show that they had thoroughly checked the form of the medicine.

The dispensary was tidy and organised. There were dedicated working areas including a clear checking area. The dispensary team placed the prescriptions and their accompanying medicines into baskets which reduced the risk of errors. The pharmacist only placed one basket at a time, for checking, in the checking area. This too reduced the risk of errors. The team used coloured baskets for different types of prescriptions and this allowed the pharmacist to prioritise her workload.

All the staff knew their roles and responsibilities. A NVQ2 trainee dispenser referred most people asking to buy 'pharmacy only' (P) medicines to the pharmacist. The other team members knew that codeine-containing products should only be sold for three days use. They would refer anyone prescribed anti-hypertensive medicines, but who asked to buy a cold medicine containing pseudoephedrine, to the pharmacist.

The pharmacy team members were clear about their complaints procedure. They had received some informal complaints, early on in the pandemic, about waiting times. Since this time, most people were grateful for the dedication and hard work of all the team members.

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's confidential wastepaper was 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 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. The pharmacist was not aware of the national 'safe space' initiative for the victims of domestic violence. She said that she would look into signing the pharmacy up to provide this service.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy currently has enough staff to manage their workload safely. The team members are flexible and try to cover holidays and sickness. They are encouraged to keep their skills and knowledge up to date. And they do this in work time. The pharmacy team work well together and are comfortable about providing feedback to their manager to improve their services and this is acted on.

Inspector's evidence

The pharmacy's current staffing profile was: one pharmacist, three full-time NVQ2 trained dispensers, one of whom was the manager, two part-time NVQ2 trained dispensers, one part-time NVQ2 trainee dispenser, one part-time medicine counter assistant and one full-time delivery driver. The part-time staff did their best to cover both planned and unplanned absences. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The pharmacist said that a nearby branch of the company was due to close soon. She anticipated an increase in workload at the pharmacy because of this. The pharmacy was currently coping with the workload but she feared a sudden increase in prescription volume, with no subsequent increase in staff, may put them under pressure.

The staff worked well together as a team. 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. Review dates would be set to achieve this. They had a staff meeting every month. All the staff felt able to raise any issues or concerns with their manager and that these would be acted on. They had recently discussed the procedures for recording the non-age prescription exemptions for their patients. Because of this, they now marked the top of the prescription with their recorded reason for the exemption. The person was then asked if it was correct. If not, the correct exemption was recorded. The prescription was then placed in a dedicated basket. The team members corrected the person's prescription medication record (PMR) during a quiet time. This change meant that the time the person was waiting was reduced and also that that the information on their PMR was accurate.

The staff were encouraged with learning and development. They completed regular e-learning in work time, such as recently on delivery payments. The dispensary staff enrolled on accredited training courses were allocated learning time. All the pharmacy team members were told about updates and current advice regarding COVID-19. All the dispensary staff reported that they were supported to learn from errors. The pharmacist documented all learning on her 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.

Inspector's evidence

The premises presented a professional image. The retail area was spacious. The dispensary was organised and tidy. The dispensing benches were uncluttered and the floors were clear. The premises were clean. As a result of COVID, the premises were cleaned thoroughly every day. The hard surfaces were wiped over more frequently than this. The team members used alcohol gel after each interaction with people.

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 these. It manages its services effectively to make sure that they are delivered safely. The team members make sure that people have the information they need to use their medicines properly. The pharmacy gets its medicines from appropriate sources and stores them safely. The pharmacy 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 south-western suburbs of the city of Bristol. Most of its prescriptions were electronically transferred from local surgeries and most were for local residents. Most of the pharmacy's regular repeat medicine prescriptions were dispensed off-site. The dispensary staff initialled the 'dispensed by' and 'checked by' boxes on the labels, so providing 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, Community Pharmacy Consultation Service (CPCS), flu vaccination service (NHS and private). It also offered private services: pneumonia vaccination, detection and treatment of urinary tract infections, supply of chloramphenicol for the treatment of bacterial conjunctivitis in children under two, supply of hydrocortisone for use on the face and treatment of impetigo. The pharmacist had completed suitable training to provide these services.

The pharmacist had started providing flu vaccinations. People wanting the vaccination booked an appointment online or in the pharmacy. 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 was seen to adhere to this advice. The pharmacist used alcohol gel or washed her hands before and after each vaccination. Everyone who received the vaccine wore a face covering.

The pharmacy had many substance misuse clients who usually had their medicines supervised. Due to COVID-19, most of these clients now collected their medicines. Several were still supervised. A

Methameasure machine was used for the assembly of methadone. Pictures of the clients were available and this reduced the risk of giving the medicine to the wrong person. The pharmacist supervised the client in the consultation room. The client disposed of the container themselves into a dedicated basket. They were offered water or engaged in conversation to reduce the risk of diversion. The supervising pharmacist washed their hands after the supervision.

The dispensary was limited in size and so the pharmacy only had a few domiciliary people who had their medicines in multi-compartment compliance packs. The staff recorded any changes in dose or other issues. The pharmacist referred to these when doing the final accuracy check. The dispensary team assembled the compliance packs on a small area of bench when it was quiet. The assembled packs were stored tidily. All the people who received their medicines in compliance packs were vulnerable and would not cope with their medicines being supplied in original packs.

The dispensary team highlighted any prescriptions containing potential drug interactions, changes in dose or new drugs to the pharmacist. The pharmacist routinely counselled people prescribed high-risk drugs such as warfarin and lithium and also those prescribed antibiotics or prescriptions with confusing directions. 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 driver 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 driver retreated and waited until the medicines had been taken safely inside. The driver annotated the delivery sheets accordingly.

The pharmacy got its medicines from AAH and Alliance Healthcare. Invoices for all these suppliers were available. The pharmacy had a scanner to check for falsified medicines as required by the Falsified Medicines Directive (FMD) but this was not yet operational. It stored its CDs tidily in accordance with the regulations and access to the cabinet was appropriate. The pharmacy had many out-of-date and some patient-returned CDs. These were clearly labelled and separated from usable stock but were occupying valuable space in the 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. These were double bagged. The staff member who accepted the returned medicines wore gloves and washed their hands after disposing of the medicines into a dedicated waste bag. 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 a recent alert 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. But its protective screens could be longer so as to provide better protection from the disease. And there could be clearer directions telling people how they should walk around the pharmcy.

Inspector's evidence

The manager had done a risk assessment of the premises regarding COVID-19. As a result of the pandemic, the pharmacy had erected two Perspex screens. But these did not cover the entire medicine counter. There were large gaps either side of the screens which could increase the risk of transmission of the disease. The team had placed some foot marks on the floor, two metres apart, indicating where people should stand. The pharmacy did not have a one-way flow of people despite it having adequate space. And it was not clear to people how they should negotiate their way around the pharmacy. All the staff were wearing Type 2R fluid resistant face masks.

The pharmacy used a British Standard crown-stamped conical measure and 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 suitable 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.