General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 74-76 Hollway Road, Stockwood, BRISTOL, Avon, BS14 8PG

Pharmacy reference: 1028651

Type of pharmacy: Community

Date of inspection: 05/12/2019

Pharmacy context

This is a community pharmacy in a residential shopping area to the south-east of the city of Bristol. Most people using the pharmacy are elderly. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy also supplies many 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

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 not all met	1.1	Standard not met	The pharmacy does not identify and manage all risks. They are behind with their work schedule and have not planned sufficiently for the busy Christmas period ahead.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have enough staff to manage its workload safely.
		2.5	Standard not met	The pharmacy is inadequately supported by the company.
3. Premises	Standards not all met	3.1	Standard not met	Not all areas of the pharmacy look professional. Large parts of the upstairs areas are damp and need repair. The company had not addressed the underlying issue despite past assurances to do so.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Not all medicines are stored safely. And, some out-of-date medicines are stored in the dispensary drawers so there is a risk that these may be supplied to people.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy does not identify and manage all risks. They are behind with their work schedule and have not planned sufficiently for the busy Christmas period ahead. Some working practices increase the risk of mistakes. And, the team could be better at learning from mistakes 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 pharmacy 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. Dispensing errors and incidents were recorded, reviewed and appropriately managed. There had been an error two weeks before the visit where saxagliptin 2.5mg had been given against a prescription calling for olanzapine 2.5mg for a patient who received their medicines in a multi-compartment compliance aid. Because of this, three independent people were now involved in the dispensing process, with the stock checked prior to assembly. Near misses were recorded but insufficient information was documented to allow any useful analysis. And, several fields were not filled in. A few learning points were identified, such as omeprazole 10mg being in the same storage place as omeprazole 20mg. But, no actions to reduce the likelihood of similar recurrences were recorded. In addition, there had been some staffing issues of late and a newly appointed manager was largely responsible for the company's 'Safer Care' procedures. These had not been completed for several months.

On the day of the visit, the pharmacy was well behind with their compliance aid workload. The part-time accuracy checking technician (ACT) was checking compliance aids needed for the next day (see further under principle 2 and 4). In addition, there were no procedures in place to accommodate the predicted very busy Christmas period ahead. The inspector secured additional hours for the ACT during the visit in order that the pharmacy could get on top of their workload and thus cope with this.

A member of staff was seen to be picking stock from a wholesale order tote. This is contrary to the company's procedures and increased the risk of errors. In addition, two outside company employees were at the branch on the day of the visit, implementing new company procedures for items that were sent off-site for dispensing. These procedures require that assembled medicines were stored in alphabetical order according to the date the prescriptions were sent to the hub. These procedures not only require more storage space, but also negate the safety aspect of a numbered retrieval system where it is highly unlikely that two patients with the same or similar surname will be stored in the same location.

The dispensary appeared spacious but the dispensing work space was limited. There was no clearly demarked assembly and checking areas. The compliance aids (blister packs) were assembled on a small area of bench despite there being a large amount of underutilised space upstairs. The assembled blister packs were transported upstairs for checking (see further under principle 4).

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 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 displayed and included questions to be asked of customers requesting to buy medicines and when customers should be referred to the pharmacist, such as specific patient groups and those requesting multiple sales. This was signed and dated and included local additions such as Nexium. A medicine counter assistant said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Ella One and referred requests for these to the pharmacist. However, none of the staff were aware of the NFA-VPS classification of veterinary medicines. The pharmacist said that he would make sure that the staff did training on this.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, 73% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback from 8% of customers about having their medicines in stock. Because of this, the pharmacy checked the stock levels of the top 150 lines every day.

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 all in order. But, the date checking records were well behind schedule (see further under principle 2).

There was an information governance procedure and the staff had also completed training on the new 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 complete e-Learning on the safeguarding of both children and vulnerable adults. The pharmacist and ACT had also 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

The pharmacy does not always have enough staff to manage its workload safely. And, the newly appointed manager is not adequately supported by the company in her new role. Those team members who are undergoing training are not allocated any dedicated learning time. So, they too feel unsupported. And, their courses may take longer than anticipated to complete. The team members are encouraged to keep their skills up-to-date but they do this in their own time.

Inspector's evidence

The pharmacy was in a residential shopping area to the south-east of the city of Bristol. They mainly dispensed NHS prescriptions with the majority of these being repeats. Several prescriptions were sent off-site for dispensing. Few private prescriptions were dispensed. Several domiciliary patients had their medicines assembled into compliance aids.

The current staffing profile was one pharmacist, one part-time accuracy checking technician (ACT), one full-time NVQ2 qualified dispenser but also the manager, four part-time NVQ2 qualified dispensers, two part-time NVQ2 trainee dispensers, one the supervisor and two part-time medicine counter assistants.

The pharmacist worked a long day, 8.30am to 7pm with just half an hour off for lunch. Most of the dispensary staff left at 4.30pm and often there was just one dispenser with the pharmacist after this time. As mentioned under principle 1, the pharmacy was behind with their workload. The inspector intervened and secured extra hours for the ACT in order for them to catch up. But, whilst this addressed the checking issues, the dispensary staff were assembling compliance aids that needed to be delivered or collected in two days' time indicating that there was also insufficient dispensary help. No clear measures had been put in place to accommodate the anticipated busy Christmas period ahead. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time.

The manager was newly appointed, eight months ago. She said that she was now supported by the cluster manager but that she was too newly appointed, August 2019. Prior to that she was largely left to her own devices. She had only had one day of training day for her new role, three weeks ago. This was seven months after starting her new job.

The company encouraged the staff with learning and development. There was compulsory leaning which had been behind schedule but now was back on track. However, the staff completed this in their own time. In addition, those staff enrolled on accredited courses, such as the NVQ2 dispensing assistant course had no dedicated allocated time for their learning. They too did this in their own time at home. The pharmacist said that all learning was documented on his continuing professional development (CPD) record.

The staff knew how to raise a concern and reported that this was encouraged and acted on by the store manager. They had recently raised concerns about heavy items being stored in the top drawers. Because of this, they had been moved to the bottom. But, as mentioned above, support from higher managment was lacking.

The pharmacist said that he was set overall targets, such as for medicines use reviews (MURs). He said that he only did clinically appropriate reviews but did feel some pressure to achieve these especially when the pharmacy was short-staffed.

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

Summary findings

Not all areas of the pharmacy look professional. Large parts of the upstairs areas are damp and need repair. The company had not addressed the underlying issue despite past assurances to do so. The consultation room is well signposted and so it is clear to people that there is somewhere private to talk.

Inspector's evidence

Overall, the pharmacy did not present a professional image. Whilst the retail area and downstairs dispensary generally looked professional, all of the large upstairs area needed serious repair. The stairs leading to the upstairs rooms had plaster peeling off the walls and the roof was said to leak. The whole area was very damp. The office was very damp and smelled unpleasant. There were large areas where the plaster was badly peeling off. There was a lot of condensation on the windows. One side of a large window in here could not be opened. The staff said that the window fell out onto a staff member in June 2019. Luckily, she was unhurt. Since then the replacement window had been kept locked.

The was a large area containing lockers which was not utilised for anything else. The stock room had a very badly damaged wet wall. Baby milk was stored in front of this. There whole room was damp and there was condensation on the windows. There was some evidence of plaster repair, not painted, which clearly had not addressed the underlying problem.

The issues about damp at the premises had been raised in the last inspection and assurances had been given by the company that these would be addressed in early 2018. The situation had deteriorated since then.

One pull-out step, to access the higher dispensary drawers, was broken and others were reported to get stuck. Pieces of metal were protruding which presented a health and safety issue for the staff.

There was a small room upstairs where the compliance aids were checked and stored. They were assembled on a small bench in the downstairs dispensary. This room contained a portable heater and did not appear damp. But, there were eight boxes of assembled medicines that had not been collected and were waiting to be returned to stock. The staff said that did not have enough time to do this.

The consultation room was quite small and the door opened inwards which may impede access by the emergency services if someone had to be placed in the recovery position on the floor. The pharmacy offered a flu vaccination service and so this was a possibility. The table in the room folded which did increase the available space for such a situation. The room was well signposted. It contained a computer but no sink. Conversations in the consultation room could not be overheard. The 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.

There was air conditioning in the downstairs areas. 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

People can access the services the pharmacy offers. The services are generally effectively managed to make sure that they are provided safely. But, the pharmacy team are behind with their work schedule in the run-up to Christmas and this could pose a risk to the safe delivery of services. The pharmacy gets its medicines from appropriate sources but they are not all stored safely. And, some out-of-date medicines are stored in the dispensary drawers and so there is a risk that these may be supplied to people.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with a push-button opening front door. Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), Community Pharmacy Consultation Services (CPCS), needle exchange, supervised consumption of methadone and buprenorphine, emergency hormonal contraception (EHC) and seasonal flu vaccinations. The latter was also provided under a private scheme as were blood pressure and diabetes monitoring. The services were well displayed and the staff were aware of the services offered.

The 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. There were very few substance misuse patients.

A large number of domiciliary patients had their medicines assembled into compliance aids (blister packs). The assembly took place downstairs and the blister packs were then transported upstairs to a small room for checking. There was a large amount of underutilised space upstairs in the pharmacy. The bench space in the room that was used for the checking of the compliance aids was only about 1.5m long. An ACT was employed for two days each week to check these. As reported under principle 1, the pharmacy was behind with both the assembly and checking of the compliance aids. The inspector secured extra hours for the ACT in the run-up to Christmas so the pharmacy could get on top of their workload. Compliance aids were being assembled on the day of the visit, a Thursday, for delivery or collection on Monday. This gave insufficient time to deal with any issues and therefore posed a risk.

The domiciliary compliance aids were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were dedicated folders for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. But, there was no concise audit trail of these for easy reference. Most of the compliance aids were checked by the ACT but the pharmacist was also required to do some checking. The assembled compliance aids were stored tidily in magazine racks.

There was a good audit trail for all items dispensed by the pharmacy. Green ‘see the pharmacist’ stickers were used. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were asked about. He 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.

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. Potential non-adherence or other issues were identified at labelling and ordering. Any patients giving rise to concerns were targeted for counselling. 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. The pharmacist reported that he frequently identified during MURs that patients prescribed non-steroidal anti-inflammatory drugs suffered with gastro-intestinal disturbances. He contacted the patient's doctor and they often prescribed a proton pump inhibiter.

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 were stored in accordance with the regulations and access to the cabinets was appropriate. But, there were several patient-returned and many out-of-date CDs. One whole cabinet in the upstairs office was full of out-of-date CDs. The manager said that she believed that out-of-dates had not been destroyed for about four years. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Date checking procedures behind schedule, 20 weeks, indicating issues with staffing. Out-of-date Tegaderm, 10/2019 was seen in the dispensary drawers. There were loose blisters of paracetamol with no batch number and expiry date. The drawer containing zopiclone had many 'split' boxes. Not all the stock had the name of the drug facing which increased the risk of errors. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be 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 23 October 2019 about co-codamol effervescent tablets. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services it provides. And, the team members make sure that it is clean and fit-for-purpose.

Inspector's evidence

The pharmacy used a British Standard crown-stamped conical measures (500ml) and ISO stamped straight measures (10 - 100ml). There were four tablet-counting triangles, two which were 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 access to the internet.

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 was 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.