General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 8-10 Horseshoe Lane, Thornbury, BRISTOL, Avon, BS35 2AZ

Pharmacy reference: 1028659

Type of pharmacy: Community

Date of inspection: 14/10/2020

Pharmacy context

This is a community pharmacy in a shopping area close to the centre of the town of Thornbury. 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 several 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) and seasonal flu vaccinations. The 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 mainly 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 learning from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team members identified and managed most 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 some of its standard operating procedures (SOPs) with changes relating to the pandemic, such as those for dealing with patient-returned medicines and the delivery of medicines to people. 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 of the details of this 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 was aware that the pharmacy 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. But they did not document enough information to allow any useful analysis, such as, in a recent quantity error with the high-risk medicine, pregabalin. It had not been recorded what was on the prescription and what had been picked. 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 pharmacy had had an error on 18 August 2020, where an incorrect medicine had left the pharmacy. The wrong strength of semaglutide injection had been supplied. Because of this, all items requiring refrigeration, such as semaglutide, now received a second check prior to hand-out.

The dispensary was spacious, tidy and organised. There were dedicated working areas, including a clear checking area and a separate area where the dispensary team members assembled the multi-compartment compliance packs. The team members placed the prescriptions and their accompanying medicines into baskets which reduced the risk of errors. And they used different coloured baskets to differentiate different prescriptions. This allowed the pharmacist to prioritise the workload.

All the staff knew their roles and responsibilities. The company's current sales protocol was displayed. A NVQ2 trained dispenser said that she would refer all sales requests for children under two to the pharmacist. The medicine counter assistant was aware that codeine-containing medicines should only be sold for three days use.

The pharmacy team were clear about their complaints procedure. The pharmacy had received several

recent complaints about the flu vaccination appointments. The pharmacy had no regular pharmacist. Some locums sent to the branch were not accredited to provide the flu vaccination service and so, appointments booked on these days, had to be cancelled. The manager had escalated this issue to her head office. Since she had done this, most locums sent to the branch were now able to provide the flu vaccination service.

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 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. Neither the pharmacist, nor the team members, were aware of the national 'safe space' initiative for victims of domestic violence. The inspector told them where they could find the appropriate information.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy currently has enough staff to manage their workload safely. The team members are informed about any changes to advice regarding COVID-19. They work well together. And are comfortable about providing feedback to their manager to improve their services and this is acted on. But the team members have limited flexibility to cover holidays and sickness.

Inspector's evidence

The pharmacy's current staffing profile was: one pharmacist, one full-time NVQ2 qualified dispenser, the manager, two part-time NVQ2 qualified dispensers, one full-time medicine counter assistant (MCA), one full-time MCA trainee and one part-time delivery driver. The pharmacy had no regular pharmacist. The manager, the only full-time dispenser, was due to leave on 23 October 2020. The team members did not know if she was going to be replaced. This caused them anxiety. They feared that they may not be able to cope with their workload. In addition, the part-time staff had limited flexibility to cover any unplanned absences. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time.

On 15 October 2020, the Divisional Quality Manager, gave assurance that the hours of the manager, who was due to leave, will be covered by another qualified dispenser in the company.

The pharmacy team worked well together. 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. The team members did not have formal staff meetings. But all the staff said that the manager was supportive and approachable. They felt able to raise any issues or concerns with her and she would act on these. A NVQ2 trained dispenser had recently raised concerns about some prescription bag labels not matching the person's prescription and the subsequent potential increased risk of errors. Because of this, all the dispensary staff had re-read the hand-out SOP and, at hand-out, they thoroughly checked the name and address of the person collecting the medicines.

The staff were encouraged with learning and development. But, at the time of the inspection, they could not access the company's e-learning programme. This had been escalated to the company's information technology department. Not all the team members had completed recent on-going learning, prior to the difficulties with access to the programme. The team members were however informed about any updates regarding COVID-19. The pharmacist seen, a locum, 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. 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 spacious, tidy and organised. It presented a professional image. The dispensing benches were mainly uncluttered and the floors were clear. The premises were clean. As a result of COVID, the premises were cleaned twice each day. The hard surfaces were wiped over more frequently than this. But the cleaning rota had not been formally updated to reflect these changes. The staff used alcohol gel or washed their hands after each interaction with anyone.

The consultation room was spacious and 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

Everyone can access the services the pharmacy offers. It manages its services effectively to make sure that they are delivered safely. The pharmacy offers face-to-face services and it has procedures to safely provide the 2020 flu vaccine. 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. It stores and disposes of them safely. The pharmacy makes sure that people only get medicine or devices that are safe.

Inspector's evidence

Everyone could access the pharmacy and the consultation room. There was a push-button opening front door. 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 close to the centre of the town of Thornbury. Most of its prescriptions were electronically transferred from local surgeries and most were for local residents. 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 some additional services: Medicines Use Reviews (MURs), the New Medicine Service (NMS), the NHS emergency hormonal contraception (EHC) service (some accredited pharmacists), Community Pharmacy Consultation Service (CPCS) and the flu vaccination service (NHS and private) (some accredited pharmacists).

The NHS in the south-west had funded a new electronic means of pre-populating the pre-assessment form for the flu vaccination, PreConsult. The pharamcy used this application. It allowed the form to be pre-populated ahead of the pharmacist consultation. PreConsult was used in two different ways. Patients scanned a QR code (a two-dimensional version of a barcode made up of black and white pixel patterns), on their own smartphone and entered their own information. Or, the pharmacy team members entered the patient's information, in the pharmacy. This application reduced the pharmacist/patient contact time and so helped to reduce the infection risk. It also increased the capacity of the pharmacy to deliver a larger number of vaccinations. People booked appointments online. The pharmacist wore a type 2 fluid resistant mask and a face shield. The consultation room was cleaned after each use. The pharmacist used alcohol gel or washed her hands before and after each vaccination. Everyone who received the vaccine wore a face covering. Some locum pharmacists sent to the branch were not accredited to provide the service and this had led to some recent complaints (see under principle 1).

The pharmacy had some substance misuse clients who usually had their medicines supervised. Due to COVID-19, all of these clients now collected their medicines. The pharmacy had several domiciliary people who had their medicines in compliance packs. The staff kept dedicated folders for these people where they 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 in a separate dedicated area. The assembled packs were stored tidily. The people receiving the compliance packs were said to

be vulnerable and would not cope with their medicines being supplied in original packs.

The dispensary team members highlighted any prescriptions containing potential drug interactions, changes in dose or new drugs to the pharmacist. The pharmacist seen routinely counselled people prescribed high-risk drugs such as warfarin and lithium and also those prescribed antibiotics, oral steroids and complex doses. 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. He 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 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 some out-of-date CDs and one patient-returned CD. These were clearly labelled and separated from usable stock. 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. It received drug alerts electronically. They were printed off and the stock was checked. The pharmacy had received a recent 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 changes to its flow of customers and the use of protective screens and equipment. But the screens are small with large gaps and do not cover the entire medicine counter. This could 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 pandemic. The pharmacy had created a marked flow of people in and out of the pharmacy. But this did not cover all the retail area. Two small Perspex screens had been erected on the medicine counter. There was a large gap between the two screens. There was no protection for the pharmacy team members at either end of these screens and no clear markings on the floor immediately in front of the medicine counter indicating that people should remain two metres away. Several people were seen to be waiting in the areas not protected by any screens and not two metres from each other during the inspection. There were some foot marks on the floor, two metres apart, but only in the signed entrance and exit route. All the staff wore Type 2R fluid resistant face masks or face shields.

The pharmacy used ISO marked straight measures and British Standard crown-stamped conical 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.