

# Registered pharmacy inspection report

**Pharmacy Name:** Lloydspharmacy, 2 Knowle West Health Park,  
Downton Road, Knowle, BRISTOL, Avon, BS4 1WH

**Pharmacy reference:** 1081973

**Type of pharmacy:** Community

**Date of inspection:** 02/03/2020

## Pharmacy context

This is a community pharmacy inter-connected with a health centre. It is situated on a large site to the south-east of the city of Bristol. There are voluntary organisations on the same site. These offer a number of health-related activities for the local community. A wide variety of people visit the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy offers a good range of services.

## 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
<b>1. Governance</b>	Standards met	1.1	Good practice	The pharmacy team take action to reduce the risk of mistakes.
		1.2	Good practice	The pharmacy learn and act on any mistakes to prevent them from happening again.
<b>2. Staff</b>	Standards met	2.2	Good practice	The team members are encouraged to keep their skills up to date and they are given time to do this at work.
		2.5	Good practice	The pharmacy team are comfortable about providing feedback to their manager to improve services and she acts on this.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Good practice	4.1	Good practice	The pharmacy offers a good range of services and everyone can access these.
		4.2	Good practice	The pharmacy team members make sure that all people have the information that they need to use their medicines properly. They intervene if they are worried about anyone. And, anyone taking high-risk medicines are targeted for counselling.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy's working practices are safe and effective. The pharmacy team take action to reduce the risk of mistakes. And, they learn and act on any 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 generally keep people's private information safe and they know how to protect vulnerable people. The pharmacy encourages people to provide feedback and raise concerns to improve its services but, does not always act on this.

### Inspector's evidence

The pharmacy team identified and managed risks. All dispensing errors and incidents were recorded, reviewed and appropriately managed. There had been a quantity error with an Ultibro inhaler in January 2020. An alert had been placed on the electronic prescription record of the patient about the error. It had also been identified that the person assembling the medicine had been interrupted to answer the telephone. As a result of the error, anyone assembling or checking any medicines, now did not interrupt their work in order to answer the telephone. Near misses were recorded and learning points were identified such as assuming that the dosage of a Clenil inhaler was the usual dose of two puffs twice a day. The near miss log was reviewed monthly as part of the company's 'Safer care' procedures. Company-wide issues were also identified by the Superintendent's Office. A risk assessment had been done in September 2019 prior to the commencement of seasonal flu vaccination service.

The dispensary was organised with dedicated labelling, assembly and checking areas. Shelves above the benches were used for items that were waiting to be checked to keep the benches as clear as possible. 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. Three independent people were involved with the dispensing process of the regular repeat prescriptions that were sent electronically from the surgery to reduce the risk of errors with these. Zomorph 100mg was stored in a red basket in the controlled drug cabinet to reduce the risk of a picking error with this.

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 included local additions such as Viagra Connect. A NVQ2 trained dispenser 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. Another dispenser knew that fluconazole capsules should not be sold to women over the age of 60 for the treatment of vaginal thrush.

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, the community pharmacy patient questionnaire (CPPQ). In the 2019 survey, 81% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. However, 14% of people had commented on the waiting areas. The staff said that there had not been any change to these as a result of this feedback. In addition, the staff said that conversations in the consultation room could be overheard and that they had received some complaints about this. They also said that it was difficult, with the pharmacy's current arrangements, to maintain the confidentiality of the patients using their needle exchange service. These issues had been escalated to higher management.

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.

An information governance procedure was in place and the staff had also 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.

The staff understood safeguarding issues and had completed the company's training on the safeguarding of both children and vulnerable adults. The pharmacist 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 met

### Summary findings

The pharmacy has enough staff to manage its workload safely. And, they are able to cover anyone who is off sick or on holiday. The team members are encouraged to keep their skills up to date and they are given time to do this at work. They are comfortable about providing feedback to their manager to improve services and she acts on this.

### Inspector's evidence

The pharmacy was inter-connected with a health centre. They mainly dispensed NHS prescriptions. Due to its location, the pharmacy had many acute 'walk-in' patients. The majority of the regular repeat prescriptions were dispensed off-site. They did not supply any medicines in multi-compartment compliance aids.

The current staffing profile was two part-time pharmacists, three full-time NVQ2 qualified dispensers, one of whom was the manager and two part-time NVQ2 qualified dispensers. All the staff covered the medicine counter. The part-time staff were flexible and generally covered any unplanned absences. Planned leave was booked well in advance and only one member of staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal with a six-monthly review where any learning needs could be identified. Review dates would be set to achieve this. The staff were encouraged with learning and development and completed monthly e-Learning such as recently on the generic 'over-the-counter' sildenafil. They spent about 30 minutes each month of protected time learning. All the staff reported that they were supported to learn from errors. The manager said that she had almost completed the NVQ3 technician course several months ago. But, at that time, she had had insufficient pharmacist support and time to complete the course. Two regular pharmacists were now employed at the branch but too much time had elapsed for her to complete the course. She would need to re-do the whole programme. The pharmacist said that that all learning was documented on his continuing professional development (CPD) records.

The staff knew how to raise a concern and said that this was encouraged and acted on. They had recently raised concerns with the manager about stock being put away in the wrong positions with subsequent picking errors. Because of this, the manager now allocated sufficient time for this task to be completed accurately. There were monthly staff meetings. All the staff were aware of the company's whistle-blowing policy. The pharmacist said that he was set targets but that he did not feel pressured by these.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy generally looks professional and is suitable for the services it provides. The pharmacy signposts its consultation room well, so it is clear to people that there is somewhere private to talk. But, the room is not completely soundproof so, some people's conversations in here can be overheard.

### Inspector's evidence

The pharmacy was well laid out and generally presented a professional image but it would benefit from updating. The dispensary was limited in size but tidy and organised. The premises were clean and mainly well maintained. However, the manager said that there had been some issues with the lights. Also, the lavatory overflow pipe, very unusually, did not drain to the outside of the premises. This meant that sometimes the floor in here flooded. The manager had escalated these issues to the company's maintenance department but, to date, they had not been addressed.

The consultation room was relatively spacious but this too would benefit from updating. A curtain was used to obscure the storage of some general items. Trim was missing from the folding table. The room was well signposted. It contained a computer and two chairs but no sink. The staff reported that conversations in the consultation room could be overheard. And, that they had received complaints about this. These had been escalated to the higher management. 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.

There was air conditioning and the temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. All the items for sale were healthcare related.

## Principle 4 - Services ✓ Good practice

### Summary findings

The pharmacy offers a good range of services and everyone can access these. It manages all its services effectively to make sure that they are delivered safely. The team members make sure that all people have the information that they need to use their medicines properly. They intervene if they are worried about anyone. And, anyone taking high-risk medicines are targeted for counselling. The pharmacy gets its medicines from appropriate sources. And, it stores and disposes of them safely. The team members make sure that people only get medicines or devices that are safe.

### Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room via a push-button opening door to the surgery. The staff could access an electronic translation application for use by non-English speakers. The pharmacy could print large labels for sight-impaired patients. A hearing loop was available.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), the Community Pharmacy Consultation Service (CPCS), the Digital Minor Illness Referral Service (DMIRS) pilot, supervised consumption of methadone and buprenorphine, sexual health service including emergency hormonal contraception (EHC) and Chlamydia treatment and seasonal flu vaccinations. The latter was also provided under a private scheme as were diabetes and blood pressure 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 sexual health services and the DMIRS. In Bristol, the latter scheme had been launched in July 2019. Since this time, about 8 to 9% of General Practitioner (GP) appointment capacity had been triaged from the GPs to community pharmacies. The scheme was planned to be rolled out nationally from April 2020 through the CPCS scheme.

Several substance misuse patients had their medicines supervised and some also took their medicines home. There were dedicated wallets for these patients where their prescriptions were kept. Any concerns about these patients were recorded on their electronic prescription medication records. The supervised patients were offered water or engaged in conversation to reduce the likelihood of diversion.

The pharmacy did not assemble any compliance aids. They did however do a Disability Discrimination Act (DDA) assessment for any patients referred from the surgery. The prescriptions for any qualifying patients were transferred to other branches for assembly. The majority of the pharmacy's regular repeat prescriptions were assembled off-site. Due to the location of the premises, the pharmacy had many acute 'walk-in' prescriptions.

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. He checked that these patients had the appropriate cards. International

normalised ratios (INR) were asked about. The pharmacist also counselled patients prescribed amongst others, antibiotics, new drugs, any changes and inhalers. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. All the staff were aware of the sodium valproate guidance relating to the pregnancy protection programme. Two 'at risk' patients had been identified and appropriately counselled. Guidance cards were included with each prescription for them.

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, such as over-ordering, were identified at labelling. Any patients giving rise to concerns were targeted for counselling. The pharmacist said that the patients were generally well informed about their medicines. He explained about potential side effects with new medicines such as a dry cough with angiotensin-converting enzyme (ACE) inhibitors such as ramipril. If any patient suffered with these, he referred them to their doctor. The pharmacist also gave healthy living advice to diabetic patients.

Medicines and medical devices were obtained from AAH and Alliance Healthcare. Specials were obtained from AAH Specials. Invoices for all these suppliers were available. A scanner was available to check for falsified medicines as required by the Falsified Medicines Directive (FMD), but not currently being used. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There was one patient-returned CD. This was clearly labelled and separated from usable stock. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Date checking procedures were in place with signatures recording who had undertaken the task. 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 20 February 2020 about ibuprofen 400mg tablets. The pharmacy had none in stock and this was recorded.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy generally 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.

### Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 100ml) and ISO stamped straight measures (25 - 100ml). There were 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 access to the internet.

The pharmacy offered a needle exchange service but the facility for this meant that it was difficult to offer the service confidentially. 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 calls 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 but conversations could potentially be overheard (see under principle 3).

### 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.