Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Lloydspharmacy online, Lower Mezzanine, c/o AAH Pharmaceuticals, Woburn Road, Warrington, Cheshire, WA2 8UH

Pharmacy reference: 9011003

Type of pharmacy: Internet / distance selling

Date of inspection: 18/01/2023

Pharmacy context

This is an internet pharmacy within a wholesaler's warehouse on the outskirts of Warrington. People access services through its website and do not enter the premises directly. The pharmacy dispenses prescriptions from a private online doctor prescribing service and provides over-the-counter medicines purchased from the company's website. People receive all medicines by delivery to their homes.

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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is associated with a prescribing service whose website allows people to select a medicine before starting a consultation with a prescriber. This makes the website appear transactional and it means there may be more risk that people may not always receive the most suitable medicine for their needs.
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 has written procedures to help the team provide its services safely. It suitably protects people's private information. And team members have the training they need to understand their role in safeguarding vulnerable people. They record and learn from mistakes they make to reduce the risk of mistakes in the future. But the pharmacy team does not always have full information about the prescribing service's policies and procedures. So, the team may not have enough information to always provide its services effectively.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) including some specifically for the supplies of pharmacy (P) medicines and dispensing of prescriptions from the online doctor prescribing service. Team members had signed to confirm they had read and understood the SOPs. Other SOPs related to the company's NHS pharmacy services and some procedures that did not apply to this pharmacy, and this may be confusing for the team. The team mostly followed the SOPs. The SOP stated that any clinical interventions should be recorded, but records of the discussions between prescribers and the team were not available. And the team confirmed they didn't make seperate intervention records that could be referred to later. There was a locum induction pack, containing the SOPs and other useful information to help locum pharmacists access the systems and provide services. The regular pharmacist wasn't aware of any risk assessments being carried out for services provided. There was, however, a governance framework in place between the pharmacy and the prescribing service. And the superintendent (SP) and chief medical officer for the prescribing service had regular meetings. The risk register was reviewed at clinical governance meetings to help minimise risk. The pharmacy team received some communications about changes to the service from the SP team following these meetings.

The SP team held prescribing policies for the prescribing service that included inclusion and exclusion criteria to support prescribers' decision making. The policy for the treatment of erectile dysfunction, used algorithms for safe prescribing and included the maximum prescribing quantities. There were policies for prescribing of steroid inhalers and for the provision of emergency contraception. Clinical guidelines were owned by the chief medical officer and were peer reviewed. But the pharmacy team didn't have access to the prescribing policies and clinical guidelines. This means the pharmacist's professional decision making during the clinical check may be compromised with the lack of information available.

Errors identified and corrected during the dispensing process, known as near miss errors, were recorded on a paper log kept in the dispensary. Team members recorded what had happened and there was confirmation of the error being corrected. But they didn't record any actions they had taken to learn from the near misses, or to avoid them being reperated. The pharmacy also made records of errors that had been identified after the person received their medicines, known as dispensing errors. These reports contained detail of what happened and learnings from the error. Most reports contained a reflective statement from team members involved. Dispensing errors were highlighted by the customer care team based at the online doctors, because the pharmacy team didn't speak to patients directly. So the learnings from these errors were reliant on a third-party information relayed to them. This means the team did not get to ask questions of the patient to improve their learning from

the error. The pharmacist completed a monthly review of all errors, and this contained details of trends, learnings and action taken. Team members described how different strengths and quantities of sildenafil had been separated on the shelves as this was reportedly a common selection error. They were not able to provide examples of any other reviews or audits that had been carried out relating to the services provided. The online doctor service shared audits with the pharmacy at SP level, including monthly audits of the prescribing for the VideoGP service. This gave assurance the service was operating in accordance with their policies.

The correct Responsible Pharmacist notice was displayed. Team members were aware of their roles and responsibilities and the supervisor and dispenser was seen referring queries to the pharmacist. Any complaints relating to dispensing services were received via the online doctor customer care team, and any relating to the sale of medicines were received via the Lloyds customer care team. The pharmacy team didn't deal directly with people who raised concerns. Most concerns raised were about delays in deliveries and when this happened the team tracked deliveries through the courier to help resolve these concerns. They reported back to the customer care teams. The prescribing service customer care contact details were advertised on the pharmacy's website. But since the new patient medication record (PMR) system had been installed there wasn't a telephone number on the dispensing labels to help people raise a concern.

The pharmacy had current professional indemnity insurance. It kept electronic private prescription records. The pharmacy did not hold any controlled drugs (CDs) and the historical CD registers had been closed correctly with nil balances. The RP record was generally completed correctly. Private prescriptions were viewed and printed from an online portal. The pharmacists were unable to see any of the prescribing records such as the answers to the online consultation questionnaire or any further communication between the prescriber, the person requesting treatment and the person's treatment plan. The directions on prescriptions for erectile dysfunction medicines stated to take according to the person's treatment plan but the team did not have sight of this. The pharmacist had been told that the person received the instructions of how to take their medicines in an email but had not seen an example. They did not know if there was a process to ensure people had received the email and understood how to take their medicines.

The pharmacy delivered medicines in discreet packaging to help maintain people's privacy. The team segregated confidential waste and it was collected and shredded offsite. The website displayed a privacy notice and team members were aware of their role in protecting people's confidentiality. It was the responsibility of the prescribers at the online doctor service to obtain consent and share details of treatment with the NHS prescriber. For certain treatments the online prescribing service made it mandatory for people to consent to communication with their regular GP before prescribers issued a prescription. This included for treatments such as asthma and cystitis. This meant people's GPs were aware of the treatment that was supplied by the pharmacy. The pharmacy team was not involved in this process.

The pharmacy had a safeguarding policy, including details of how to raise a safeguarding concern. The pharmacist had completed level two safeguarding training. Team members had a general understanding of how to safeguard vulnerable people. But because they had no direct contact with people, they couldn't think of a situation they had needed to raise a concern. Prescriptions included people's age and gender, which allowed some checks on the suitability for vulnerable people, for example on treatments for emergency contraception. The pharmacy had received assurance from the online doctor service that its staff were trained and that doctors, prescribing pharmacists and SP team members were trained to safeguarding level 3. The safeguarding policy stated that for higher-risk treatments such as initial supplies of weight loss medication and supplies of emergency contraception and contraception there would be an in-pharmacy review. However this was not seen in practice

and supplies for emergency contraception and contraception were made without a review. The SP team later explained that this requirement did not apply to the online pharmacy but only to the branches where people could pick up their medicines in person. They explained that prescriptions for these medicines in the online pharmacy had been subject to additional safeguarding checks made at prescribing level and so didn't need a review. They confirmed that the safeguarding policies would be updated.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the appropriate qualifications and skills to provide its services. It comfortably manages its workload. Team members complete ongoing learning to keep their knowledge up to date. And they meet to discuss ideas to improve services and to learn from mistakes. Team members know how to raise a concern and they feel comfortable doing so.

Inspector's evidence

The pharmacy routinely had two pharmacists working in a day. One of the pharmacists would start early and the other later. There was an overlap period over the course of the day. The pharmacy had a manager, who managed across two sites, and was available to contact by telephone for any issues. On the date of the inspection the RP was a locum pharmacist, who was present in addition to two other pharmacists. The locum RP had been arranged as contingency for a possible absence. The RP had worked at the pharmacy before and had received an induction about the pharmacy's ways of working, her role and tasks she was expected to complete as RP. There was a regular employed pharmacist working and she was seen supporting the supervisor and the rest of the team with their work. There were four qualified dispensers, plus the supervisor was also a dispenser. There was another team member, who was not involved in any dispensing tasks but assisted the pharmacy in packing medicines for despatch. He did not have a formal qualification but had received training appropriate for his role. The team appeared to be managing the workload effectively and did not appear to be working under pressure. Team members confirmed the daily work was completed before the couriers or postal service came to collect the deliveries at the end of the day. There was another pharmacy premises in the warehouse and several of the team members working there were trained to cover in this pharmacy for absences and holidays. The team worked to staffing rotas to ensure numbers and skill mix remained appropriate.

Team members explained the e-learning modules they completed to keep their knowledge up to date. These modules were not specific to the pharmacy's services and were the ones completed by all team members working in Lloyds branches. Any changes in services or specific information relating to the pharmacy was relayed by the regular pharmacist and the team informally discussed other topics, such as new medicines. Team members didn't have sight of any prescribing policies, clinical guidelines, or treatment plans from the online doctor service to help them in their roles and in their professional decision making. They described how sometimes they contacted prescribers via an online messaging service to resolve queries. They couldn't show the outcome of these online conversations and whether the supply was made or refused.

Team members had regular meetings to discuss patient safety learnings from near miss and dispensing errors. These meetings provided them with the opportunity to provide feedback on services and to put forward ideas to improve ways of working. Team members had suggested adding a barcode to the private prescriptions, so that the details of the person populated directly into the patient medication records (PMR). This had been reported up to management and acted upon. The team reported this helped with efficient working and improved accuracy and therefore safety. Team members felt the regular pharmacists were approachable and they felt comfortable in raising concerns. The pharmacy had a whistleblowing policy that some team members knew about. They described a previous concern that had been raised and resolved appropriately. Team members had previously received appraisals

which provided the opportunity for individual feedback and discussions about development, but they reported this had not happened recently. Services were not incentivised. The SP team had received assurances regarding the completion of a structured induction for prescribers working at the online doctor service.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy is well-maintained and appropriately clean and secure. And the premises provide a suitable environment for the team to work and provide services. But the pharmacy is associated with a website that allows people using its prescribing service to select a medicine before starting a consultation. This makes the service appear transactional. And it means there may be more risk that people might not always receive the most suitable medicine for their needs. And some information on the website is inaccurate and incomplete, which may cause confusion.

Inspector's evidence

The pharmacy premises were clean and large enough for the services provided, with enough space for the storage of medicines and space on work benches for dispensing and packing. There was a separate checking bench, situated so the RP could supervise the dispensing process. The area at the far end of the premises was cluttered with delivery returns, but it didn't pose a health and safety hazard and the pathway through to the fire exit was clear. There was a separate room for administration tasks. It had distinct workstations for the printing and processing of prescriptions prior to dispensing. There was sufficient lighting and heating was appropriate for the storage of medicines and so team members could work comfortably. There were staff facilities within the building for the team to use. The dispensary had a clean sink with hot and cold running water. The pharmacy premises were well-maintained.

The company website included information on the range of services that Lloydspharmacy, as a company offered. Some of which were provided by this pharmacy. The website detailed the pharmacy's registration number at the bottom of the main LloydsPharmacy page, along with the company's details. The "contact us" page detailed the name of the superintendent, but not her registration number and the registration number of the pharmacy on this page was for a pharmacy that was no longer registered. The website was not clear as to which services this pharmacy provided, including the dispensing of prescriptions from the online prescribing service.

The website had a separate tab, where people accessed the private online doctor prescribing service. There was information about the prescribers providing the service, their qualifications, their specialities, and experience. People accessed a page with information on the condition and the range of treatments offered. But people selected the medicine they wanted before starting an online questionnaire consultation. The different "select a treatment" buttons on the conditions page, led the person back to selecting a medicine before starting a consultation. Depending on the treatment the person also selected the quantity, for example for a Ventolin inhaler and/or also selected the strength of the medicine for example for a Symbicort inhaler. This made the service look transactional.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy suitably manages its medicines, and it stores them appropriately. People can easily access medicines and services. And overall, the pharmacy manages its services effectively. But members of the pharmacy team do not have direct contact with people they supply medicines to. And they do not always take the opportunity to make sure people know how to take their medicines correctly.

Inspector's evidence

People accessed the pharmacy's services through the company's website. There were separate pathways on the website for buying medicines and accessing treatment from the online prescribing service. For most treatments people completed an online questionnaire consultation, which the prescribers used to prescribe treatments. There was also the option advertised for people to pay for a video consultation with a prescriber and prescriptions generated from these consultations were dispensed at the pharmacy. The pharmacy delivered these prescriptions and also pharmacy (P) medicines to people's homes. The pharmacy used recognised courier and the postal service to provide delivery.

The pharmacy received prescriptions from private consultations that were based on the completion of a medical questionnaire. This was for a limited range of conditions and treatments. People could also pay for a video consultation with a prescriber to access a wider range of treatments. People didn't speak with the pharmacist and pharmacy team directly, but instead all queries were answered by the two different customer service teams, one for the prescribing service and one for medicine sales. When the pharmacy team was asked questions the answers were relayed back to the person by the customer service team. A person's telephone number and email were on top of the prescription, but the pharmacist couldn't recall using them to contact a person directly about their medicines. The pharmacy's website provided some health information about conditions, treatments, and medicines. But the pharmacy didn't have any healthcare leaflets to supply to people with their medicines and it didn't provide any counselling information for the medicines supplied, for example for new medicines or advice on the use of inhalers.

The prescribing service was CQC regulated. The SI team had received assurance about the security of the electronic prescribing system and confirmed access was restricted to individual pharmacists and doctors associated with the service. There was a defined process for managing identity (ID) checks using a third-party authentication service to verify a person's identity and this included system checks to ensure people were over 18 years.

The pharmacy received electronic private prescriptions through the prescribing system portal, and these were processed at clearly defined workstations and prioritised according to the urgency of delivery. The postal address labels were printed, checked for accuracy, and attached to the prescription to ensure the labels stayed with the correct prescription. There was no access through the prescribing system portal to view people's consultation questionnaires or other information and the pharmacy didn't have any information such as weight or blood pressure to help with the pharmacist's clinical checks on the suitability of supplies. The pharmacy processed prescriptions from video consultations separately and kept the medicines for this service in a separate area from other medicines as there was a range of different medicines used. This helped to reduce selection errors when dispensing

prescriptions from the consultations using questionnaires. There was a wider range of medicines that were prescribed by video consultation, including antidepressants.

The pharmacy used baskets as part of the dispensing process to help keep the prescriptions and medicines for a person together and reduce the risk of errors. And they split the workload into different coloured baskets according to the courier being used, as they collected at different times of the evening. The team signed dispensed by and checked by boxes on the labels to complete an audit trail of dispensing. When the pharmacists completed clinical checks on prescriptions, they didn't routinely use the PMR to identify repeat supplies and change in doses. They relied on this being spotted by the dispensers during the labelling process. There was no formal process for the dispensers to do this and they didn't highlight information such as the date of last supply to the pharmacist to help them assess whether the supply was appropriate. A dispenser remembered highlighting a query to the pharmacist for a person who had received several supplies of the emergency contraception Ella One which seemed unusual. The pharmacist and dispenser did not remember the outcome of the query with the prescriber. The pharmacy used an electronic messaging system to contact prescribers and the customer service team. The team reported that this system worked well, and they received responses to queries quickly, so people's prescriptions could be completed the same day for delivery. Of a sample of messages seen, most were reporting out-of-stock medicines and one example showed when a pharmacist wanted to speak directly to a prescriber about a prescription. The pharmacy didn't record the outcome of interventions to be able to refer to in the future or to look for trends. A small sample of records were checked and an example of treatment for erectile dysfunction was seen, where sildenafil had been supplied within two days of tadalafil and then subsequent supplies were for sildenafil. This seemed unusual, but there was no record of it being queried to check it was clinically appropriate. Another example was seen where a person had received nine supplies of Ella One in a six-month period. Two supplies were within a week of one another. It was not known whether these supplies had been queried to confirm they were clinically appropriate. Because the pharmacist did not have access to prescribing policies and clinical guidelines they were unsure whether there was a policy covering repeat supplies of Ella One or maximum quantities to be prescribed for erectile dysfunction medicines.

The team worked in clearly defined areas to label, check and pack prescriptions and these areas were kept tidy to avoid errors. Medicines were packed in sturdy, discreet cardboard packaging, before being stored ready for the courier's collection at the end of the day. If there was a delay in delivery, the supervisor described how they tracked individual packages to resolve queries. Some packages were returned to the pharmacy undelivered and the reason for the failed deliveries was investigated by the pharmacist.

The pharmacy received electronic requests for purchases of Pharmacy (P) medicines that people ordered through the website. People completed a questionnaire, which a pharmacist assessed for suitability of supply before authorising. If a supply was denied due to an inappropriate answer this was logged on the system. However, the person could attempt to reorder the medicine and change the answers to the questionnaire. It was at the pharmacist's discretion whether to supply the medication based on the new questionnaire. Rejected supplies were logged and the pharmacist provided a reason for the rejection. The pharmacist demonstrated a document which had common reasons for rejection for each condition and they referred to this as needed. For example, Canesten cream would not be supplied to people with diabetes. The person received a refund if the order was rejected. P medicines generally had to be ordered by the person who required treatment, unless they were ordering medication for a child, for example paracetamol suspension. Once authorised the team processed these sales in a separate area of the pharmacy to avoid mix up with the prescription only medicines.

The pharmacy obtained medicines from recognised sources, including from the wholesaler on site. Fast

moving lines, such as medicines for erectile dysfunction, were stored on shelves in totes and ordered in bulk to help with stock rotation and efficiency of working. The team labelled the totes and shelves with the medicine, quantity, and strength to help reduce selection errors. Medicines that were not used as frequently, for example those prescribed following a video consultation, were stored neatly on shelves with different medicines and strengths clearly separated. The pharmacy made regular checks to help ensure medicines were safe and suitable to supply. A team member recorded fridge temperatures daily. Only one medicine was stocked that required storage at this temperature. For dates in January 2023 the maximum temperature had been recorded as above eight degrees Celsius on several occasions. This was highlighted to the pharmacist to further investigate. The temperature was in range at the time of the inspection. Team members used a date checking matrix which highlighted when to check different areas of the dispensary and this was up to date. All medicines from a sample checked were in date. There were some short-dated medicines seen and only some of which had been highlighted as such. The team received notification of medicine alerts and recalls and had a suitably robust process of checking and recording their actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services efficiently. The team uses the equipment and facilities in a way that protects people's private information.

Inspector's evidence

The pharmacy team had access to the company's resources and intranet. There was access to the internet to obtain up-to-date clinical information and other information to provide safe services. It used the PMR system that was installed in other company branches, and the team had reported some issues since it was installed in the summer. The PMR system didn't link directly to the prescribing system and so when the team received the electronic private prescriptions from the online doctor service portal, data was then inputted from the prescription firstly by scanning a QR code to populate the person's details and then manually inputting other details from the prescription. Both systems were accessed with a username and password to protect people's private information and the team used their own passwords to access the systems. The team had IT contact details to report any maintenance issues and the equipment appeared in good working order. There was a conveyor belt running through the pharmacy from the wholesalers that brought totes of medicines into the pharmacy, which was an efficient way to receive stock particularly for the P medicine orders.

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.