Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy.com, 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: 30/11/2023

Pharmacy context

This is a pharmacy based within a wholesaler's warehouse on the outskirts of Warrington. It dispenses private prescriptions from an associated private online doctor prescribing service accessed from the website www.onlinedoctor.lloydspharmacy.com It sells some over-the-counter medicines. People receive all medicines by delivery to their homes.

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 suitably identifies and manages risks with its services. It has written procedures and clinical guidelines to help its team members provide its services safely. It keeps the records it must by law, and it has insurance to protect people if something goes wrong. The pharmacy keeps people's confidential information safe, and it trains its team members so they know how to help vulnerable people. Team members learn from mistakes they make and change the way they work to reduce the risk of similar mistakes.

Inspector's evidence

The pharmacy had reviewed its standard operating procedures (SOPs) since the previous inspection, and they were relevant to the services provided. There were additional SOPs for the use of the newly implemented patient medication record (PMR) system, these SOPs were dated 2019 and so were due for review. All but two team members had signed to confirm they had read and understood the SOPs and completion by the other two team members was planned. The pharmacy had copies of the clinical guidelines used by the online prescribing service, which was a CQC regulated prescribing service. It included a pharmacy guide detailing information that helped the pharmacy team clinically check and dispense prescriptions. There were prescribing policies for a variety of conditions, including for asthma and weight loss which incorporated a risk assessment for each set of treatments. It was mandatory for the prescriber to inform the person's regular prescriber for some treatments such as asthma and weight loss. There was a clear indication in the guidelines for maximum quantities to prescribe and at what intervals. The pharmacists, including new pharmacists had signed to confirm reading them. This helped make checks on the supplies to make sure they were appropriate for the person receiving it.

The pharmacy had a documented plan of audits for the following year, with the first starting in early January. This included clinical audits on overuse of emergency contraception, asthma prescribing and prescribing of Wegovy for weight loss. The plan had been agreed jointly with the chief medical officer, pharmacy superintendent (SI) and the deputy superintendent. The deputy SI was based in the pharmacy and the SI at the online prescribing clinic. There was a governance framework that ensured the deputy superintendent was aware and involved in planned changes to the service and there were regular clinical governance meetings every two weeks to help ensure the pharmacy was kept informed of changes and involved in decision making. Specific agreed actions from meetings were documented on an electronic workload platform so it was clear who was responsible.

Errors identified during the dispensing process, known as near miss errors, were recorded regularly with entries each month. Team members recorded what had happened and confirmation of the error being corrected. And there were some actions taken and learning documented. The deputy SI completed analysis of these errors monthly and shared learning with the team. Different strength and quantities of sildenafil were kept in separate boxes on shelves as this was reportedly a common selection error. 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. The learnings from two recent errors, identified a contributing factor to be the implementation of the new PMR system. This had informed changes in the ways of working with the PMR to help prevent similar mistakes. The pharmacy team rarely spoke to people about errors as the customer care team based at the online doctors was the point of contact for patients. So, learnings

from these errors were somewhat reliant on a third-party information relayed to them.

The correct Responsible Pharmacist (RP) notice was displayed. Team members were aware of their roles and responsibilities. Team members involved in packing the medicines for delivery were suitably trained for their role and knew not to be involved in the dispensing process. Complaints relating to dispensing services were received via the online doctor customer care team, who contacted the pharmacy. Delays in deliveries were resolved by the pharmacy team tracking deliveries via the courier's website and they responded to those concerns. The online doctor customer care contact details were advertised on the website so people could provide feedback about the prescribing service and the pharmacy.

The pharmacy had current professional indemnity insurance. It kept electronic private prescription records, which met requirements. The pharmacy did not hold any controlled drugs (CDs). The electronic RP record was completed correctly from the sample of entries checked. Prescriptions from the prescribing service were viewed and printed from an online portal. The pharmacists were unable to see the prescribing records, such as the answers to the online consultation questionnaire or further communication between the prescriber and person requesting treatment to help them complete their clinical check. The pharmacy contacted prescribers when they had queries or required additional information. The team kept records of interventions and regular examples were seen since January 2023. This included identification of a duplicate account, an interaction with a P medicine resulting in a prescription medicine being refused and an intervention showing contact with a patient following a drug interaction identified between Alli and levothyroxine.

The pharmacy displayed a privacy notice. Team members had signed to confirm they had read the Information Governance pack about confidentiality in the pharmacy. They delivered medicines in discreet packaging to help maintain people's privacy and segregated confidential waste to be collected by a third-party contractor and shredded offsite. The team had a safeguarding policy, to refer to and it included details of how to raise a safeguarding concern. The pharmacist had completed level two safeguarding training. Team members had completed level 1 safeguarding in October 2023 and a team member explained how monitoring repeat supplies helped protect potentially vulnerable people. Prescriptions included people's age and gender, which allowed checks on suitability for treatments such as emergency contraception. The online doctor prescribing team were trained to safeguarding level 3.

Principle 2 - Staffing   ✔ Standards met

Summary findings

The pharmacy has appropriately skilled and qualified team members to manage the workload and provide services safely. They complete a thorough induction when they start so they have the knowledge and skills for the role. And they complete ongoing learning to keep those skills up to date. Team members feel comfortable suggesting ideas to improve ways of working. And they have options to raise concerns should they need to.

Inspector's evidence

The pharmacy had two pharmacists working at the start of the inspection, with another pharmacist joining later in the morning. The deputy SI worked full time in the pharmacy during the week and provided consistency and professional support to the team. Two pharmacists worked at weekends. The pharmacists worked in the dispensary checking prescriptions, clinically checking prescriptions on the IT system and authorising Pharmacy (P) medicine supplies. Locum pharmacists completed an induction to understand the pharmacy's processes and what was expected of them in their role. There were six dispensers, plus a supervisor, who was also a dispenser. There were team members, not involved in dispensing tasks, who assisted in packing medicines for despatch. The team appeared to be managing the workload well. Team members confirmed the daily work was completed before the couriers came to collect the deliveries at the end of the day. The team worked to staffing rotas to ensure numbers and skill mix remained appropriate and the deputy SI managed staff resourcing. Since the last inspection, the workload had increased, and additional locum dispensers had worked when there were periods of pressure.

Team members completed some e-learning modules to keep their knowledge up to date, the latest included training on safeguarding. The deputy SI relayed information to the team about changes in services and specific information relating to the pharmacy. And the team 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. A team member, who had recently started working in the pharmacy, described how she felt supported in her induction by the pharmacists and other team members. Her induction involved shadowing other team members, completing learning modules and reading SOPs. Team members described the deputy SI as approachable and felt comfortable in raising concerns. The pharmacy had a whistleblowing policy. Services were not incentivised.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are large, clean, and secure. And the space and layout are suitable for the services provided. The website portrays a professional image.

Inspector's evidence

The pharmacy premises consisted of two rooms one for administration and prescription processing tasks and a large dispensary. They were clean and tidy. Both rooms were separated into different workstations which helped with the organisation of tasks and workflow. The areas were large enough for the services provided, with enough space for the storage of medicines and space on work benches for dispensing and packing. Since the last inspection, the workload had increased, and additional workstations had been built. Pharmacists worked on separate checking benches. There was sufficient lighting and heating was appropriate for the storage of medicines and for team members to work comfortably.

The walkways were kept clear, including the pathway through to the fire exit at the far end of the dispensary. 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 online doctor website included the pharmacy's registration number along with the company's details. The names and qualifications of the prescribers working at the online doctors were available. The website layout met GPhC Guidance, and the overall layout portrayed a professional service. The new superintendent's details had not been added to the website.

Principle 4 - Services   ✔ **Standards met**

Summary findings

The pharmacy manages and delivers its services safely and effectively. And it uses barcode technology to help reduce errors. It completes checks on way it delivers its medicines to make sure they are suitable to use when people receive them. The pharmacy obtains it medicines from recognised suppliers. And it manages and stores its medicines as it should.

Inspector's evidence

People accessed the pharmacy's services through the website www.onlinedoctor.lloydspharmacy.com. The website provided information about conditions, treatments, and medicines supplied. Queries for the service were directed to the online doctor's customer service team and this team contacted the pharmacy if they needed to answer queries.

The pharmacy dispensed private prescriptions from the CQC regulated online doctor service. The private consultations were based on the completion of a medical questionnaire. This was for a range of conditions that included erectile dysfunction, contraception, hair loss, asthma, and weight loss. Access to the electronic prescribing system was restricted to role and prescribers had individual log in credentials. Once a prescriber was registered on the system a key was generated, known only to them to help ensure the electronic prescriptions were valid. There was a defined process for managing identity (ID) checks using a third-party authentication service to verify a person's identity. This included 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. The pharmacy had recently introduced a different PMR system, which allowed an electronic clinical check by the pharmacist before prescriptions were assembled. They had access to check the person's PMR dispensing history to help with the check. The system had been used for less than a month, so most supplies were seen to be the first supply on the system. This system was separate to the prescribing system portal and currently there was no access to view people's consultation questionnaires. The pharmacy didn't have information such as weight or blood pressure to help with the pharmacist's clinical checks on the suitability of supplies. Once the pharmacist's clinical check was complete the prescription was released for labelling and dispensing. Prescriptions were processed in batches and kept in order throughout the process, so people's prescriptions were completed according to when they were received and according to urgency.

The prescription was scanned into the PMR system, which populated the prescription data. This was checked by the dispenser. Barcode technology was used to scan medicines to confirm the correct medicine and strength had been selected. The system then released the label for printing. Baskets were used at each step of the dispensing process to help keep prescriptions, postal labels, and medicines together to help reduce the risk of errors. Team members split the workload into different coloured baskets according to the courier being used, to prioritise workload. Prescriptions were dispensed in batches according to the medicine, the strength and pack size on the prescription. This helped minimise selection errors. Team members logged on to the PMR and this recorded which team member

completed which task to form an audit trail of dispensing. The pharmacy used an electronic messaging system to contact prescribers and responses to queries were received in a timely manner. The pharmacy printed off additional patient information leaflets, to add to packs when the quantity dispensed was less than an original pack.

Since the last inspection, the pharmacy had started dispensing injectable weight loss medicines, and these required cold storage. The website was clear about stock issues, showing Saxenda out of stock, and there were restrictions on the supply of Wegovy to ensure continuation of supply for existing patients. Team members had received training. The pharmacy had a copy of the prescribing service's clinical guidelines for weight loss which had clear exclusion criteria. The guidelines gave assurances of BMI checks and the questions asked before prescribing was authorised. The consultation didn't rely only on the online questionnaire, the guidelines confirmed the use of video to check suitability to prescribe. The pharmacy didn't receive information about BMIs so could not check whether supplies were within licensed indications, and they couldn't monitor weight loss for suitability of continued supplies. The pharmacy had completed checks on the stability of these medicines in transit by sending medicines through the delivery postal and courier system packed in several ways. This information was used to produce clear guidelines of how to package these medicines for delivery. A team member was observed packing these medicines in line with the pharmacy's guideline, which included using insulating material, cool packs, and fridge stickers. The pharmacy used the postal system and a recognised courier to deliver medicines to people's homes. Prioritised, tracked deliveries were made for fridge lines and for urgent medicines such as emergency hormonal contraception treatments. Individual packages could be tracked, and this function was used 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 as it was not suitable for the person, this was logged on the system and the pharmacist provided a reason for the rejection. There were documented common reasons for rejection for each condition, that pharmacists referred to. For example, Canesten cream would not be supplied to people with diabetes. The person received a refund if the order was rejected. P medicines had to be ordered by the person who required treatment unless they were ordering medication for a child. 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 separate shelves in large boxes and ordered in bulk to help with stock rotation and efficiency of working. The team labelled the boxes and shelves with the medicine, quantity, and strength to help reduce selection errors. Medicines that had been used as part of the video consultation prescribing service, which was currently on hold, were stored on shelves in a different room to avoid selection errors with the fast-moving line. The team was unsure what was happening to the stock should the service not restart. The pharmacy made regular checks of its medicines. It had started dispensing weight loss medicines that required refrigeration since the last inspection. It stored these neatly, with different strengths separated in baskets in medical grade full height fridges. Fridge temperatures were recorded daily, and temperatures were 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. The pharmacy received notification of medicine alerts and recalls and team members recorded the actions taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it uses its equipment in a way to protect people's confidential information.

Inspector's evidence

The pharmacy team had access to the reference resources and the internet to obtain up-to-date clinical information and other information to provide safe services. The pharmacy's equipment appeared in good working order, including the medical grade fridges. And the freezers holding ice packs used for the delivery of fridge lines.

The pharmacy had recently installed a different PMR system, and the team reported there was good support from the company for training and if it went wrong. The company's contact details were displayed on the wall. The PMR system didn't link directly to the prescribing IT system. Both systems were accessed with individual username and passwords, which were role specific. Information on computer monitors were protected from unauthorised personnel, due to their positioning and restricted access to the pharmacy. There were separate workstations in the administration area to help with privacy.

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.