General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lytchett Pharmacy, 16 High Street, Lytchett Matravers, POOLE, Dorset, BH16 6BG

Pharmacy reference: 1089348

Type of pharmacy: Community

Date of inspection: 06/12/2022

Pharmacy context

This is a community pharmacy in the semi-rural village of Lytchett Matravers, Dorset. The pharmacy dispenses NHS and private prescriptions. The pharmacy's team members sell over-the-counter (OTC) medicines and provide advice. They offer the New Medicine Service (NMS), local deliveries, seasonal flu and travel vaccinations. The pharmacy also supplies some people's medicines inside multi-compartment compliance packs if they find it difficult to take them. And it offers a private, travel vaccination service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.1	Good practice	The pharmacy ensures the risks associated with providing its services are effectively identified and managed.
2. Staff	Standards met	2.2	Good practice	Members of the pharmacy team have the appropriate skills, qualifications and competence for their role and the tasks they undertake. Team members in training are appropriately supported.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy's services are delivered safely using verifiable processes. Members of the pharmacy team are promoting safe practice for people with undetected high blood pressure. And the regular, locum pharmacist provides a high quality, reliable, and bespoke travel vaccination service for people in the local and wider community.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has appropriate systems in place to identify and manage the risks associated with its services. Members of the pharmacy team deal with their mistakes responsibly and learn from them. They also understand their role in protecting the welfare of vulnerable people. The pharmacy protects people's private information well. And generally, maintains its records as it should.

Inspector's evidence

Overall, this was a well organised pharmacy with competent staff and only a few areas for improvement. The pharmacy had a suitable range of systems in place to identify and manage risks associated with its services. This included keeping the pharmacy clean and tidy. Stock was stored in an ordered way and team members were seen to work efficiently. During the dispensing process, staff processed prescriptions in batches, they selected medicines against prescriptions, concentrated on one task at a time and worked in designated areas. This included a separate area to prepare multi-compartment compliance packs. Once prescriptions had been assembled, the responsible pharmacist (RP) carried out the final accuracy-check in a specific area. This helped minimise distractions. The inspector noted that an hour before closing for lunch, the team had cleared their workload. This helped them to focus on housekeeping and other tasks. The inspector was told that this was normal practice and a direct result of the owner's internal set procedures. Systems and processes had been kept simple so that the team could focus on other responsibilities.

The pharmacy had a suitable process in place to deal with incidents and complaints. The RP's process was in line with this and included identifying the root cause, reviewing internal processes as well as documenting details. Near miss mistakes were routinely recorded. Staff explained that the regular locum pharmacist documented and reviewed them, highlighted them as well as discussed them with the team. In response look-alike or sound-alike medicines were separated and medicines which required greater care had been highlighted on shelves. The inspector spoke to the regular, locum pharmacist after the inspection. He explained that the pharmacy had recently changed this process. The information previously being recorded for near miss errors was not sufficiently detailed, in order to capture and learn more from these events, the sheets used to record this information had been updated over the past few weeks and the first, formal monthly review was due to take place.

The pharmacy had a range of current, electronic standard operating procedures (SOPs). The SOPs provided guidance for the team to carry out tasks correctly. The staff had signed them to verify that they had been read with new members of the team were working their way through them. Team members knew their roles and responsibilities. They also had designated tasks and responsibilities. The correct notice to identify the pharmacist responsible for the pharmacy's activities was rectified when highlighted and placed on display. The inspector and staff could also not locate an SOP about safeguarding although the team described seeing and reading this.

The pharmacy's team members had been trained to protect people's confidential information and could safeguard vulnerable people. They recognised signs of concern, described being vigilant when serving customers and knew who to refer to in the event of a concern. The pharmacy displayed contact details for the relevant agencies. The RP had been trained to level two through the Centre for Pharmacy Postgraduate Education (CPPE). The consultation room had details of the company's chaperone policy

on display and a previous certificate of achievement awarded by NHS England highlighted that the pharmacy was dementia friendly. Confidential material was stored and disposed of appropriately. There were no sensitive details that could be seen from the retail space. Computer systems were password protected and staff used their own NHS smart cards to access electronic prescriptions. The pharmacy also had information on display so that people were informed on how their sensitive data was protected.

The pharmacy's records were mostly compliant with statutory and best practice requirements. This included a sample of electronic registers seen for controlled drugs (CDs). On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. The pharmacy had appropriate professional indemnity insurance in place. The RP record and records about emergency supplies had been appropriately completed. Records verifying that fridge temperatures had remained within the required range had also been routinely recorded. However, there were missing or incomplete details of prescribers in electronic records of private prescriptions.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Members of the pharmacy team work well and efficiently together. The pharmacy's team members are suitably trained or appropriately supervised. And they have a range of skills and experience.

Inspector's evidence

Staff at the inspection included the RP who was employed by the pharmacy and usually worked at another of the owner's pharmacies in the area, two dispensing assistants and a medicines counter assistant (MCA). Team members wore name badges. One of the dispensing assistants was relatively new, the other was the supervisor, and apart from the new member of staff, they were fully trained in their respective roles. The new dispensing assistant explained that other members of staff and the pharmacist supervised her activities. She felt supported and all members of the team said that they enjoyed working at the pharmacy. Some members of the team were long-standing. There was also a regular locum pharmacist (see Principle 4), three part-time delivery drivers, another part-time, dispensing assistant and MCA. The pharmacy had enough staff to support the workload and the team was up to date with this.

The MCA knew which activities could or could not take place in the absence of the RP and was suitably knowledgeable about the medicines which could be purchased over the counter. People were asked appropriate questions before they were sold and if unsure or if people requested more than one product, staff checked with the RP. All members of the team were observed to be hard-working and organised, they also worked well and independently from the RP. They were a small team, so details or concerns were discussed frequently. Performance reviews were informal, but staff explained that they could easily raise concerns and hold discussions about their progress if required. The pharmacy staff had access to resources from a pharmacy support organisation but after completing formal training, they were provided details about updates or new products through the regular locum or owner and read trade publications or magazines. Using online resources in a more structured way to help with ongoing training was discussed at the time. There were no targets in place to achieve services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a professional environment for the delivery of its services. The premises are clean and secure. And there is enough space available for its services to be provided safely.

Inspector's evidence

The pharmacy premises were clean, well ventilated and maintained appropriately, with good lighting. The pharmacy was also secure and safeguarded from unauthorised access. The premises consisted of a spacious retail area, a medium-sized dispensary, consultation room, stock room and a staff rest area. The dispensary benches were kept clear of clutter and there was enough space available to manage the workload safely. Pharmacy (P) medicines were stored behind the front counter which restricted access. The pharmacy’s retail space also had a consultation room available to provide services and private conversations. The room could be locked and there was no confidential information accessible from this space. The premises were professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s working practices are safe and effective. The pharmacy obtains its medicines from reputable sources, it stores and manages them well. And it keeps appropriate records to verify how its services are being run. The pharmacy also provides beneficial services to the local and wider community. This includes increasing the number of people being screened for high blood pressure. This has helped detect and treat more people who were previously undiagnosed. And reduced the risk of associated conditions developing. In addition, the pharmacy provides comprehensive travel advice and safely administers the appropriate vaccines. But team members don't always counsel or record any information for people who receive higher-risk medicines. This makes it difficult for them to show that they provide people with appropriate advice when these medicines are supplied.

Inspector's evidence

People could enter the pharmacy through a wide front door at street level and the retail space was made up of some clear, open space as well as wide aisles. Staff explained that if people struggled to open the door, they assisted them with this. This meant that people with restricted mobility or using wheelchairs could easily enter and access the pharmacy's services. There was one seat if anyone wanted to wait for their prescription and plenty of car parking spaces available outside. Counter staff described speaking slower, directing their conversation at people as well as pronouncing their words better for people who were partially deaf. They offered deliveries when needed and used gestures to assist people whose first language was not English.

The workflow involved the team using baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. They were also colour coded which highlighted priority. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process. Team members routinely used these as an audit trail. Staff were aware of the risks associated with valproates, they had previously identified people at risk, who had been or were due to be supplied this medicine, counselled them accordingly and provided relevant literature. The latter was available, and the team was currently in the process of completing the new audit for this. People prescribed other higher-risk medicines were routinely identified, but relevant parameters such as blood test results were not regularly asked about and no details were documented to help verify this.

The pharmacy team described providing seasonal flu vaccinations previously this season. This service was not currently provided due to a lack of stock availability. The pharmacy offered local deliveries and the team kept the appropriate records to verify this service. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended.

The pharmacy also supplied some people's medicines inside multi-compartment compliance packs once the person's GP or the team had identified a need for this. The pharmacy ordered prescriptions on behalf of people for this service and specific records were kept for this purpose. Any queries were checked with the prescriber and the records were updated accordingly. All medicines were removed from their packaging before being placed inside them. Descriptions of the medicines inside the compliance packs were provided and patient information leaflets (PILs) were routinely supplied.

The inspector spoke to the regular locum RP following the inspection. He explained that the pharmacy team had been providing a blood pressure (BP) service which was led by support staff. Team members had been appropriately trained before taking people's BP, they had consistently been providing this service and increased the number of people being checked. If the BP was high, people were referred to their GP or their ambulatory BP could be monitored and checked over a 24-hour period before they were effectively counselled or referred. This meant that the GP could then easily review the management of this condition. People were often seen by their GP the same day and came back with prescribed medication. The local surgery adjacent to the pharmacy, had also been referring people to the pharmacy for this service. Increasing the number of people's BP being checked, increases the detection of undiagnosed high blood pressure in the local population, reduces the risk of associated conditions such as heart disease, heart attacks and strokes but also positively impacts on health inequalities.

The inspector was also informed that the regular locum pharmacist provided a vaccination service from the pharmacy. He was a pharmacist independent prescriber (PIP) and explained that whilst he had initially trained in substance misuse therapy, after considering his own practice and the risks associated with an in-house, pharmacy prescribing service, he had created a bespoke, travel vaccination service which was provided solely by him. The locum RP had completed appropriate initial training on travel vaccinations with the Royal College of General Practitioners (RCGP) as well as annual refresher. He was accredited to offer and was the lead for yellow fever vaccinations. The pharmacy was registered with the National Travel Health Network and Centre (NaTHNaC) to offer this, and the locum received regular updates by email from NaTHNaC which helped him to easily keep abreast of any changes.

This pharmacist explained that prescribing, supplying and administering travel vaccinations was relatively low risk because most of the vaccines currently available were well-established. Many were inactivated and other than a risk of a severe reaction to the vaccine (anaphylaxis), there was a lower chance of harm occurring. Side effects could be easily managed, usually with appropriate counselling. The pharmacy had SOPs in place to cover the practice and administration of the vaccines. Guidelines on travel health and immunisations from the Royal College of Nursing (RCN) were used. Risk assessments had also been completed. The locum pharmacist initially commenced this service in January 2022, and he was due to complete a prescribing audit on the past year's practice. Internal audits had been completed as well as the audit for yellow fever as required by NaTHNaC.

In addition, the locum RP had created a bespoke, private prescription software program to record consultation details, generate private prescriptions and send details to the person receiving the vaccine as well as their GP. The locum explained that on initiating this service, he had identified that it was not possible to record appropriate consultation notes on patient medication records (PMR) from the pharmacy's system. The latter was not set up for this, so he developed a different system and internal database which could be used in combination. This included a two-factor authorisation process to generate digital private prescriptions, only three pharmacists (another prescriber and the owner of the pharmacy) had access to this system and once the prescription had been created, it remained under the sole control of the prescriber. This was in accordance with the law for electronic prescriptions. In addition, he had developed specific patient questionnaires, informed consent was initially taken, the locum then worked through each point before counselling, administering and, or supplying. People using this service were offered the option of having their private prescriptions dispensed elsewhere. This often occurred when vaccines were out of stock, or if they were not injectable such as malaria chemoprophylaxis and cholera.

This was a busy, successful and widely advertised service (https://purbecktravelclinic.com/). People

from the wider Dorset area and further afield (such as London and Cardiff) had used this service. Every review on Google had rated the service with 5 stars and frequently mentioned the name of the locum PIP as well as the high quality of the service provided by him. The locum pharmacist explained that feedback was consistently sought, and he encouraged people in writing to do this so that he could improve the provision and quality of this service. Processes linked to the software were also currently being further developed to enable other pharmacists to provide this service in the locum's absence. Adverse events were monitored. There had been no complaints or incidents associated with this service.

The pharmacy obtained medicines and medical devices through licensed wholesalers such as AAH, Alliance Healthcare, Lexon and Phoenix. Dispensed fridge and CD medicines were stored within clear bags. This helped to easily identify the contents upon hand-out. CDs were generally stored under safe custody. Medicines stored in the dispensary were kept in an organised manner. The team date-checked medicines for expiry regularly and kept records of when this had been carried out. Short-dated medicines were identified. No date-expired or mixed batches of medicines were seen. Medicines returned for disposal, were accepted by staff, and stored within designated containers. Drug alerts were received by email and actioned appropriately. Records were kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy keeps its equipment clean and has a suitable range of facilities. The equipment is used appropriately and helps protect people’s personal details.

Inspector's evidence

The pharmacy was equipped with current versions of reference sources and relevant equipment. This included counting triangles, a range of clean, standardised, conical measures, a pharmacy fridge, a legally compliant CD cabinet and a clean sink that was used to reconstitute medicines. Hot and cold running water was available as well as hand wash and hand sanitisers. The pharmacy had its computer terminals positioned in a way and location that prevented unauthorised access. The pharmacy also had cordless phones so that private conversations could take place away from the retail space if needed.

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.