General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hythe Pharmacy, 1-2 Hythe Quay, Colchester, Essex, CO2 8JB

Pharmacy reference: 9012036

Type of pharmacy: Community

Date of inspection: 10/09/2024

Pharmacy context

This community pharmacy is located in Hythe, near Colchester. It provides a variety of services including dispensing of NHS prescriptions and the New Medicine Service (NMS). The pharmacy has a clinic next door where it provides other services including travel vaccinations, the Pharmacy First service patient group directions (PGDs) carried out by nurse and pharmacist independent prescribers. The pharmacy previously provided a prescribing service but has since stopped this and instead supplies medicines under PGDs.

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	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 largely manages all the risks associated with its services. It has carried out risk assessments of its clinical services. The pharmacy routinely keeps records of all consultations it has with people. Its team members record and regularly review any dispensing mistakes to learn from these events. And the pharmacy generally keeps the records its needs to by law. People can provide feedback about its services. And its team knows how to protect vulnerable people.

Inspector's evidence

The correct responsible pharmacist (RP) notice was displayed in the pharmacy. The RP was also the superintendent pharmacist (SI). The pharmacy provided a wide range of services. These services were provided face-to-face at the clinic next to the pharmacy. These were registered as one premises. The SI explained that all services were currently being provided via patient group directions (PGDs) and the prescribing service had stopped. The SI said that the main services provided under PGDs were travel vaccinations, weight loss treatments, and the Pharmacy First service. There was currently a nurse prescriber, a pharmacist prescriber (PIP) who was also the owner and the SI who was not a PIP who worked in the clinic. The pharmacy had a risk assessment in place for the weight loss medicine service as well as a general prescribing risk assessment that had been created following action from the previous inspection. The SI provided assurances that should the pharmacy start providing a prescribing service again, the appropriate risk assessments would be completed, and appropriate training undertaken.

For the weight loss service, there was a set of screening questions before the clinician would undertake a full weight check to work out the BMI. People would need to have to have a BMI of above 30 to qualify for the various weight loss treatments. The pharmacy offered the option for people to consent to share information about the medicines they had been supplied with their regular GP. And the SI explained this information would then be sent by the receptionist at the clinic. Evidence of emails being sent to the people's GP surgeries for both weight loss treatment and travel vaccinations was seen during the inspection.

Documentation of consultations was done electronically and for all records seen a treatment plan was documented by the clinician. People receiving treatment for weight loss were seen monthly by a clinician where treatment was reviewed including the person's weight and if they were experiencing any side effects. Evidence was seen of treatment being stopped in people experiencing side effects and also referrals being made to people's GPs who were deemed not suitable to start treatment. Appropriate counselling advice was routinely being documented including red flags and safety netting advice. For people who needed travel vaccinations, the batch numbers of injections were regularly being recorded and were stored in the clinic.

Following action from the previous inspection, the pharmacy had completed an audit of the consultations at the clinic for the first quarter of the year which showed that the pharmacy had recorded consultation notes for all consultations that had been undertaken in that time period and that consent to share the information with the persons GP had been asked to all people. It also showed that for all people who gave consent, their GP had been contacted. The pharmacy had not yet completed an audit for the second quarter of the year, but the SI said that this would be done as a priority and

regularly quarterly audits of the service would be completed going forward.

Team members knew their roles and responsibilities in the pharmacy. And they were observed working in a safe and efficient manner. There was a range of standard operating procedures (SOPs) available for the activities completed in the dispensary, and there was a record to show that team members had read the SOPs. The SOPs were overdue a review the previous month, the SI said these would be updated. Team members knew what activities they could and could not do in the absence of a pharmacist. The team recorded near misses (dispensing mistakes spotted before a medicine left the pharmacy) on paper sheets that were kept in the dispensary. The pharmacy manager and SI reviewed the near misses at the end of each month for any trends or patterns in the types of near misses occurring and this was documented and kept with the near miss records. Dispensing errors (mistakes that were not detected before a medicine was handed out) were recorded on paper sheets in more detail than near misses. Team members said a dispensing error had not occurred for some time but, if an error occurred, an error report would be completed, and a meeting would take place to discuss the error.

People could submit complaints or feedback about the pharmacy in several different ways, including by email, in person or by phone. The pharmacy manager said she would usually record and resolve any complaints but could escalate to the SI if necessary. Confidential waste was shredded on site when no longer needed. No confidential waste was found in the general waste bins. And no person-identifiable information could be seen from outside the dispensary. The SI confirmed he had completed safeguarding level three training with the Centre for Pharmacy Postgraduate Education (CPPE) and that all dispensary team members had completed safeguarding level one training. There was also a folder in the dispensary with details of local safeguarding contacts.

The pharmacy had current indemnity insurance. Records in the controlled drug (CD) register were complete and balance checks were carried out somewhat regularly. A random check of a CD showed the quantity in stock matched the running balance in the register. Records about private prescriptions were not always complete with several entries seen missing the name and address of the prescriber. The SI said these details would be included going forward. Records about emergency supplies of medicines did not always contain an appropriate reason for nature of the supply. The SI said that in future, all emergency supplies would have a suitable reason recorded for the nature of the supply. The RP record was generally complete with only a couple of entries missing a finish time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely. And team members do the right training for their roles. Pharmacy team members have a regular formal review of their progress. And they feel comfortable about providing feedback or raising concerns if needed.

Inspector's evidence

The dispensary team consisted of the SI, the pharmacy manager, an accuracy checking technician (ACT), three dispensers, a counter assistant and a delivery driver. The clinic team consisted of a pharmacist who was an independent prescriber (PIP) and split his time between working in the pharmacy and the clinic, a nurse prescriber and a receptionist. The SI also worked in the clinic but was not a prescriber.

The SI confirmed the pharmacy had enough team members to manage the workload and the team was up to date with dispensing. He confirmed all dispensary team members had either completed the appropriate training with an accredited training course or were currently enrolled on one. The pharmacy manager said the team did ongoing training in the pharmacy and shared relevant updates such as clinical guideline updates to the pharmacy team. All team members had a yearly formal appraisal to review their performance and were given objectives to work towards. Team members said they had no issues raising any concerns and would usually go to the pharmacy manager or SI with any issues they had. Team members confirmed they were not set any targets relating directly to services.

The SI said that he, the PIP and nurse prescriber had all completed training relevant to the services they were providing in the clinic including weight loss, travel vaccinations and the Pharmacy First service. The PIP had completed his prescriber course in hypertension and had completed courses for physical examination and diagnosis and consulting in minor ailments. The SI said that all clinicians undertook regular continuing professional development (CPD) in areas related to their roles and had regular refresher training about travel vaccinations.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and tidy and provides a safe and appropriate environment for people to access its services. People can have a conversation with a team member in a private area. And the pharmacy is kept secure from unauthorised access.

Inspector's evidence

The front facia of the pharmacy was in a good state of repair and was modern and professional looking. The pharmacy had chairs for people who wished to wait to access the pharmacy' services. Pharmacy-only (P) medicines were stored securely behind the counter. The pharmacy had a consultation room for people who wished to have a conversation in private. It was clean and tidy and allowed for a conversation at normal volume to be had without being heard from the outside. However, the door of the room contained small windows which meant privacy may not be completely maintained in the room, but there were consultation rooms in the clinic which could be used if required. The shop floor area of the pharmacy was clean and tidy, but the dispensary area was somewhat cluttered which may have made it difficult for team members to carry out their work efficiently. The SI provided assurances that the dispensary would be tidied up. There was just enough space for the team to work in. And there was a sink for preparing liquid medicines which was clean. The temperature and lighting in the pharmacy were adequate. And it had air conditioning to adjust the temperature if required. The pharmacy had a staff toilet with access to hot and cold running water and handwash. The pharmacy was kept secure from unauthorised access.

The clinic area of the pharmacy was very clean, modern looking and professional. It had three clinic rooms, a reception desk and a waiting area with chairs for people to wait to be seen. The pharmacy's website could be used to book appointments at the clinic, but people could not have remote consultations via the website. The website had details of team members working in the pharmacy including the SI as well as the address of the pharmacy and clinic and the pharmacy's registration number.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides all its services safely. It regularly shares information about the medicines it supplies through its clinic with people's regular prescribers, where people have given consent for this to happen. And it records all its consultations. The pharmacy dispenses medicines safely and stores its medicines appropriately. It gets its medicines from reputable sources. And the team takes the right action in response to safety alerts and recalls ensuring that people get medicines that are fit for purpose.

Inspector's evidence

The pharmacy clinic mainly operated as a pre-booked service. Walk-in appointments were also offered if an appointment slot was available. Consultations took place face-to-face in dedicated consultation rooms within the clinic. Medicines were only supplied to people after they were assessed face-to-face.

The prescribers kept records of consultations on a separate electronic system. This was password protected and only the prescribers and SI had access to this. The records of prescriptions issued, and medicines supplied by the pharmacy were checked on the pharmacy system where the pharmacist working in the pharmacy could see how many medicines had been prescribed and how often, this allowed them to intervene if needed. Prescribers used appropriate clinical guidelines to aid clinical decision making. The clinical team members worked under PGDs to provide all current treatments. These had comprehensive information covering the key questions to ask before supplying the medicines. These were signed by the SI to give authorisation to administer the treatment. Furthermore, the PGDs were available online and there were records of the vaccinations supplied including batch numbers and expiry dates which were kept in a separate folder in the clinic.

Appropriate questions were asked during consultations and the prescribers used their own professional judgement when supplying medicines under a PGD. The SI confirmed that medicines that were high-risk such as those liable to misuse were not issued by the clinic. The face-to-face consultation for weight loss covered all the key information and documented records of BMI. The SI explained that if the BMI was above 30 the prescriber would supply. The SI stated that if a person did give consent, the pharmacy would send information to the GP about the medicines it had supplied.

Both the pharmacy and clinic had step-free access via a ramp and manual doors. The pharmacy was able to cater for people with different needs, for example by printing large-print labels for people with sight issues. It also had a hearing loop. There was just enough space for wheelchairs and pushchairs to access the dispensary counter. The dispensary had separate areas for dispensing and checking medicines. Baskets were used to separate prescriptions and reduce the chance of prescriptions getting mixed up. Checked medicines that were seen contained a dispensing label which had the initials of the dispenser and checker, and this provided an audit trail. The pharmacy provided a delivery service to people who had difficulty collecting their medicines. The pharmacy provided the driver with a delivery list which the driver returned to the pharmacy. This was then stored in a folder in the dispensary. If there was a failed delivery, a note was put through the door to arrange redelivery and the medicines returned to the pharmacy.

The pharmacy used stickers to highlight prescriptions that contained a high-risk medicine, a CD or an

item requiring refrigeration. The SI confirmed that he always handed out high-risk medicines and that people received the appropriate counselling for their medicines. Team members were aware of the risks of sodium valproate, and the SI knew what to do if a person in the at-risk category presented at the pharmacy.

Multi-compartment compliance packs were prepared in a separate area at the back of the dispensary. Packs seen contained the all the required dosage and warning information for the medicines. The packs also had a description of the contents, which included the colour, shape, and any markings on the medicines to help people identify their medicines. Team members confirmed that patient information leaflets (PILs) were included monthly with all packs. They also stated that they would contact the surgery regarding any queries they had with prescriptions such as unexpected changes to people's treatment.

The pharmacy obtained medicines from licensed wholesalers and invoices were seen confirming this. CDs requiring safe custody were stored securely. Medicines requiring refrigeration were stored appropriately. The pharmacy had two fridges, one for storing stock in the dispensary and one for storing stock in the clinic. Fridge temperatures for both fridges were checked and recorded daily, and all records seen were in the required range. And the current temperatures were within the required appropriate range during the inspection. Expiry date checks of medicines were carried out monthly on a rota basis with a different section of the pharmacy being checked each time. The pharmacy used stickers to highlight stock soon to expire. A random check of medicines on the shelves found no out-of-date medicines. Safety alerts of medicines and medical devices were received by email. These were actioned as appropriate and archived in a folder kept in the dispensary.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide a safe and effective service. And it uses its equipment to protect people's privacy.

Inspector's evidence

The pharmacy had computers with access to the internet, allowing the team to access any online resources it needed. Computers were password protected and faced away from public view to protect people's privacy. Team members were observed using their own NHS smartcards, and the pharmacy had cordless phones to allow conversations to be had in private. The pharmacy had appropriate glass measures for measuring liquids which were clean. And it had triangles for counting tablets and a separate one for cytotoxic medicines such as methotrexate to prevent cross-contamination; these were clean also. There was a blood pressure machine in the consultation room and the SI confirmed that it was new and did not currently require replacement or recalibration. The SI said that equipment had been safety tested in the past but could not confirm when, he said he would check and get the equipment retested if necessary.

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.