General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Drayton Prime Pharmacy, 274 Havant Road, Drayton, PORTSMOUTH, Hampshire, PO6 1PA

Pharmacy reference: 1031800

Type of pharmacy: Community

Date of inspection: 25/07/2023

Pharmacy context

This is a Healthy Living Pharmacy (HLP) in a residential area of Drayton on the northern outskirts of Portsmouth. It dispenses NHS and private prescriptions. It also sells a range of over-the-counter medicines and provides health advice. The pharmacy offers flu vaccinations in the autumn and winter seasons. And home deliveries for those who cannot get to the pharmacy themselves.

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 provides its services in a safe and effective manner. It has up-to-date written instructions for its team members to follow so that they can provide their services safely. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They understand their role in protecting vulnerable people, and they keep people's private information safe. The pharmacy generally keeps satisfactory records and has appropriate insurance to protect people if things go wrong.

Inspector's evidence

There was a file containing written standard operating procedures (SOPs) which had been signed by all staff to say that they had read and understood them. Although the pharmacy had been moving the SOPs online, the team still relied upon the paper copies. They had last been reviewed and updated in June 2022. There was a written business continuity plan to help team members maintain services in the event of a power failure or other major problem. They also knew how to contact the owner or superintendent pharmacist (SI) if they needed to.

Records of errors (those mistakes discovered after the medicines had been handed out to people) and near miss mistakes (those discovered while still in the pharmacy) were kept in a folder by one of the workstations. But the new barcoding system used for dispensing prescriptions had significantly reduced them. The responsible pharmacist (RP) held weekly meetings during which they discussed any incidents, what had been learned and how they might be prevented in future. They didn't keep any records of those meetings, but upon reflection the RP agreed that it would be a good idea to keep some notes. The meetings also covered other topics regarding the safe operation of the pharmacy. The RP described how one meeting resulted in them having a new staff holiday chart to help ensure they always had sufficient cover. Some medicines had been identified as being prone to error, such as the 'look alike sound alike' (LASAs) medicines amitriptyline, amlodipine and atenolol. There were labels on the shelves highlighting these items among others, so that staff knew to take extra care when selecting them. The audits and 'mock inspections' highlighted in the previous inspection were being carried out much less frequently than before.

Roles and responsibilities of staff were documented in the staffing file, setting out their key tasks. Those questioned were able to clearly explain what they do, what they were responsible for and when they might seek help. They outlined their roles within the pharmacy and where responsibility lay for different activities. Staff were able to describe what action they would take in the absence of the responsible pharmacist, and they explained what they could and could not do. The responsible pharmacist (RP) notice was clearly displayed for people to see, and the paper RP record was complete.

There was a 'complaints notice' on display for people to see, advising them of the process to follow if they wanted to make a complaint in accordance with NHS requirements. There was also a notice encouraging people to provide feedback on the pharmacy's service, and a suggestions box was on the counter. A certificate of professional indemnity and public liability insurance, valid until September 2023, was on display in the dispensary.

Private prescription records and emergency supply records were maintained on the patient medication

record (PMR) system and were complete with most details correctly recorded. But the same prescriber details were used for most of the entries. The RP acknowledged that this was incorrect and explained that they found it difficult and time consuming to find the correct details on their online system. Upon reflection she agreed to ensure that they would record the correct prescriber details in future. The CD register was seen to be correctly maintained, with all running balances checked at regular intervals in accordance with the relevant SOP. Running balances of three randomly selected CDs were checked and found to correspond with the stock balances recorded in their respective registers. Records of unlicensed 'specials' were seen, and most of those examined were found to be correct and complete. A few were missing the required prescriber details. The records of unwanted CDs returned by people for safe disposal were complete although there were a number of items still awaiting destruction and safe disposal. The inspector advised the RP and the SI to destroy them in accordance with the correct procedures at the earliest opportunity. There were several denaturing kits available, and the RP indicated that she could easily obtain more, or bigger ones, if needed.

Those team members questioned were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. They had all signed confidentiality agreements and were able to provide examples of how they protect patient confidentiality, for example checking people's identity before discussing their medication, or inviting them into the consulting room when discussing sensitive information. Completed prescriptions were stored in labelled trays where they could not be seen by people waiting. There was a large bin into which bagged prescriptions were placed, prior to team members scanning the bag label and then placing the bag in the indicated tray. Confidential waste was kept separate from general waste and shredded onsite. A privacy notice and data use poster were on display near the entrance for people to see in accordance with current requirements.

There were safeguarding procedures in place and contact details of local referring agencies were seen on the dispensary wall for all staff to access. There were also a number of safeguarding posters near the entrance to the pharmacy for people to see as they came in. The pharmacist had completed level 2 safeguarding training, and most of the team had been trained to level 1 so that they could recognise potential safeguarding risks. There were certificates on display to show who had completed the safeguarding training. All staff were either dementia friends, or undergoing the necessary training..

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely, and they work well together. The pharmacy provides its team members with enough time and appropriate resources for their ongoing training needs. Team members have a clear understanding of their roles and responsibilities. And they can make suggestions to improve safety and workflows where appropriate.

Inspector's evidence

There were five dispensing assistants, three medicines counter assistants (MCAs) and the RP on duty during the inspection. This was a mix of experienced and new staff. It appeared to be appropriate for the workload and everyone was working well together. In the event of staff shortages, part-time staff could adjust their working hours to provide additional cover. The RP added that he could also call upon help from their neighbouring pharmacy branch if necessary.

There were certificates on display to show what training had been completed. There was a staffing file containing details of the staff induction process for new team members. One of the dispensing assistants was responsible for maintaining the records and for ensuring that everyone completed the required training. He explained how he arranged time for everyone to complete their training, usually on Wednesdays when they were quieter. The RP also demonstrated the online platform they used for staff training, highlighting the modules they completed. Some of this was also a requirement of the pharmacy quality scheme (PQS). There was a notice on display highlighting the pharmacy's whistleblowing policy.

Those staff members questioned were able to demonstrate an awareness of potential medicines abuse and could identify patients making repeat purchases. They described how they would refer to the pharmacist if necessary. All staff were seen to serve customers and asking appropriate questions when responding to requests or selling medicines. There was no pressure to achieve specific targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a secure and professional environment for people to receive its services. The pharmacy keeps its premises clean and satisfactorily maintained. It has a suitable consultation room which it uses for some of its services and for sensitive conversations. The pharmacy is sufficiently secure when closed.

Inspector's evidence

The pharmacy premises were modern, clean, tidy and in a reasonable state of repair with step-free access via an automatic door to the street. The retail area was spacious and open, allowing plenty of space for wheelchair users. There was a large, well laid out dispensary with several workstations, providing sufficient space to work safely and effectively. There was a clear workflow in the dispensary and the layout was suitable for the activities undertaken. There was a cleaning rota in place and one of the dispensing assistants described how they had maintained the cleaning routine they had established during the pandemic.

There was a clearly signposted consultation room available for confidential conversations, consultations and the provision of services. Both doors to the consultation room were kept closed but not locked when not in use, but there was no confidential information visible. The dispensary sink had hot and cold running water. There was handwash available. Room temperatures were appropriately maintained by a combined air-conditioning and heating unit, keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner. And people with a range of needs can access them. The pharmacy sources, stores and manages its medicines safely, and so makes sure that the medicines it supplies are fit for purpose. The team responds satisfactorily to drug alerts or product recalls so that people only get medicines or devices which are safe. Team members know how identify people supplied with high-risk medicines so that they can give them extra information they may need to take their medicines safely. They keep appropriate records of most of the checks that they do make, and of the pharmacy's other services. This enables them to show what they have done if a query should arise in future.

Inspector's evidence

The pharmacy was providing a range of NHS services including the community pharmacist consultation service (CPCS), the New Medicine Service (NMS) and seasonal flu vaccinations. The pharmacy also offered free deliveries to people who couldn’t visit the pharmacy in person.

Controls were seen to be in place to reduce the risk of picking errors, such as the use of baskets to keep individual prescriptions separate. Prescription labels were no longer initialled to show who had dispensed and checked them, as their new PMR systems used barcode scanning to create an audit trail of each step in the dispensing process. The RP demonstrated how the system worked, showing who had completed each step of the prescription journey from receipt to handing out. The SI also explained how he had set the system to ensure that any items whose barcode wasn’t recognised by the PMR, were always referred back to the pharmacist. The same applied to split packs, and other team members could not override this. Owings tickets were used if the pharmacy was unable to supply the entire prescription. The prescription was kept in the owings box until the stock arrived. In the event of being unable to obtain any items, they contacted their other local branch or the manufacturers to see if they had any stock before contacting the GP for an alternative.

Completed prescriptions for CDs were highlighted on the barcoded label produced by the PMR system so that staff would know that they needed to look for a bag in the CD cupboard. Uncollected schedule 3 and 4 CDs were monitored via the PMR system to ensure they weren’t handed out after their expiry date. The RP explained that they checked the retrieval shelves every month and that any prescriptions that had remained uncollected for more than three months, or CDs for more than 28 days, were removed and details recorded in a file. Any expired EPS tokens were returned to the NHS spine. Fridge lines in retrieval awaiting collection were also highlighted so that staff would know that there were items to be collected from the fridge.

Multi-compartment compliance aids were now dispensed in the company’s neighbouring branch. The SI explained that they had recently merged the two pharmacies so that only the premises currently being inspected remained on the NHS Pharmaceutical list. The other premises acted only as a hub for assembling compliance aids for this pharmacy. The RP described how they dispensed any acute or interim prescriptions for people whose regular medicines were normally supplied in compliance aids. The new PMR system enabled both branches to view the records so that all the necessary checks could be made before dispensing the interim prescriptions.

Staff were aware of the risks involved in dispensing valproates to women in the at-risk group. The RP checked their records to show that all those the currently supplied valproates to were outside the at-risk group. She confirmed that they had the necessary information leaflets available, that they dispensed complete original packs, and that they didn't obscure any warnings with their dispensing labels. The RP also knew to record any interventions on the PMR system. The risks associated with unopposed oestrogen were also discussed, and the RP confirmed that they always referred people back to their GP if necessary.

There were approximately a dozen people using the substance misuse service. Some were supervised taking their medicine each day, and others collected a week at a time. Appropriate records were kept, and key workers contacted in the event of non-collection for three consecutive days.

Deliveries were made by the pharmacy's employed delivery drivers who kept appropriate records of each delivery using an online app. They obtained a signature upon delivery, and any failed deliveries were returned to the pharmacy. The app also enabled the pharmacy to track the driver so that they could give people an estimated delivery time if required.

The pharmacy received referrals from the NHS111 service for the CPCS via the PharmOutcomes online platform. The RP indicated that the majority of referrals came at the weekend, and most were simply for advice. All the necessary records were completed on PharmOutcomes. Some included requests for emergency supplies. Although the reason for supply was recorded, there wasn't enough detail to show why the supply was needed. Upon reflection the RP agreed to include more in future.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance, Colorama, Sigma and Bestway. Unlicensed 'specials' were obtained from Colorama. Routine date checks were seen to be in place, with those items due to expire in the near future highlighted. Those due to expire within the next month were removed for safe disposal. No out-of-date stock was found. Opened bottles of liquid medicine were annotated with the date of opening. There were no plain cartons of stock seen on the shelves and no boxes were found to contain mixed batches of tablets or capsules.

Fridge temperatures were checked daily and a record kept in a sleeve attached to the fridge door. The records for one of the fridges were incomplete, but all those records examined were found to indicate the correct temperature range. Pharmacy medicines were displayed behind the medicines counter, preventing unauthorised access or self-selection of those medicines.

Patient-returned medicines were screened to ensure that any CDs would be appropriately recorded, and that there were no sharps present. Patients with sharps were signposted to the local council for disposal. The disposal bins were kept in a separate room away from other stock items. Denaturing kits for the safe disposal of CDs were available for use.

The pharmacy received drug alerts and recalls from the MHRA via 'Pharmdata'. This system enabled the pharmacy to differentiate between those alerts which they had acted upon, and those which did not affect them. There was a record of what action had been taken, who by and when. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for the range of services it provides. It uses its facilities and equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy had the necessary resources required for the services it was providing, including the consulting room itself, a selection of crown stamped measuring equipment (including a separate measure clearly marked for methadone only). There were counting triangles (including a separate one for cytotoxics) and reference sources including the BNF and BNF for children. The pharmacy had internet access and frequently used this as an additional reference source. All surfaces and equipment were frequently cleaned to help minimise the risk of transmitting the virus.

Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Everyone used their own login ID for the PMR system so that it could maintain an accurate audit trail of their activities. Computer screens were positioned so they were not visible to the public. Staff were seen to take precautions such as moving to the rear of the dispensary when making telephone calls so as not to be overheard. NHS smartcards were seen to be used appropriately and with no sharing of passwords. They were not left on the premises overnight. Confidential information was kept secure.

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.