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: 16/08/2024

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 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 not all met	1.1	Standard not met	Members of the pharmacy team have been allowed to take short cuts when using the patient medication record system to assemble people's prescriptions. This failure to follow the relevant standard operating procedures can be considered as having significantly contributed to an undetected error being made.
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 not all met	4.3	Standard not met	The pharmacy is unable to show that medicines needing to be stored in a refrigerator, have been kept within the correct temperature range over a period of several months.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not do enough to ensure its team members follow the written instructions that are there to help them complete their tasks safely. While team members follow most of those instructions satisfactorily, they are not following all of those relating to their dispensing system. This makes it more likely that its safety features won't work properly, and mistakes may go unnoticed. The pharmacy does regularly review those instructions and keeps them up to date. Although the pharmacy does record the mistakes its team makes, it relies too heavily on its dispensing system so that some mistakes may not be recorded and then missed out of any analysis of what may be going wrong. The pharmacy generally maintains its records as it should. Its team members can explain what they do, what they're responsible for and when they might seek help. They keep people's personal information suitably secure and understand their role in helping protect vulnerable people.

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 planning for some time to move its SOPs online, the team still relied upon the paper copies. Most of them had last been reviewed and updated in May 2023. There were also some SOPs issued in May 2022 specifically relating to the use of the pharmacy's Patient Medication Record (PMR) system. Those SOPs set out the steps that team members should follow when dispensing prescriptions, including the order in which they should do them. There was an SOP for picking stock, which was followed by an SOP for scanning and labelling prescriptions. Point 7 of this SOP stated that staff should 'put the dispensing label immediately on the manufacturer's pack you have selected after scanning the pack.' Team members confirmed that they didn't always follow this sequence and instead they scanned all the packs they needed and attached labels afterwards because it was quicker and more convenient. This practice negated the additional safety features afforded by scanning the barcodes on each pack individually and applying the labels immediately. And there have been errors made which could have been prevented had the PMR system been used in accordance with the SOPs. 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 no longer kept in a folder by one of the workstations. Instead, the team relied upon the PMR's barcoding system to identify and record their near misses and errors. The regular pharmacist demonstrated how the system identified their overall trends which appeared to be improving. However, having discussed the type of error highlighted above, the pharmacist accepted that they system alone wasn't able to identify all types of near miss or error, and that they should reconsider manually maintaining a paper record. One of the dispensing assistants held weekly meetings during which they discussed any incidents, what had been learned and how they might be prevented in future. They now kept notes of those meetings, but those notes seen didn't contain very much detail. The meetings also covered other topics regarding the safe operation of the pharmacy. 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 pharmacy had a file with some audits of its procedures that had been carried out with the support of

one of the pharmacy membership organisations.

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 (RP), and they explained what they could and could not do. The RP notice was clearly displayed for people to see, but there were gaps in the paper RP record. The SI updated the missing information during the inspection, and the current RP explained that she thought the PMR automatically logged her in as RP.

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, along with an electronic tablet device by the front door. The certificate of professional indemnity and public liability insurance on display in the dispensary was out of date. But the regular pharmacist contacted their insurers who confirmed that cover was still in place. A new certificate was subsequently printed.

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 there were some missing prescriber details. Records of unlicensed 'specials' were seen, and those examined were found to be correct and complete.

The controlled drug (CD) register was seen to be correctly maintained, with all running balances checked every other Sunday, in accordance with the relevant SOP. Any alterations were made using an asterisk with a signed and dated footnote, explaining the reason for the alteration. A sample of CD running balances were checked and found to correspond with the entries in their respective registers. The records of unwanted CDs returned by people for safe disposal were complete. There were denaturing kits available for the team to safely dispose of CDs.

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, and not leaving confidential information on the counter.

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 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has plenty of staff with a suitable mix of skills and experience. They manage their workload well, supporting one another as needed. 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 know when to seek help or refer to the pharmacist.

Inspector's evidence

There were two dispensing assistants, three medicines counter assistants (MCAs) and the locum RP on duty at the beginning of the inspection. The pharmacy's full team comprised a mix of skills and experience. During the course of the inspection the regular pharmacist, the SI and another MCA arrived. This 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 SI added that they could also call upon help from their neighbouring pharmacy branch if necessary.

There were certificates on display to show what training had been completed. The two dispensing assistants had both completed the required accredited training. One of the MCAs had also completed their accredited training and two of the others were currently working through their courses. The fourth MCA had not started any accredited training but explained that he had only been at the pharmacy for a short while and would be leaving shortly. There was a staffing file containing details of the staff induction process and an induction workbook for new team members. Those for established team members also included their annual performance reviews. Team members were allocated training time each week, usually on Wednesday afternoons when the local surgeries were closed. There was an online platform they used for staff training, showing each of the modules they were working on and completed. 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 people 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 the services it provides. 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. And its website includes the required information about the pharmacy.

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, with all staff involved in wiping down work surfaces, cleaning keyboards, floors and toilets daily. Shelves were wet-cleaned monthly.

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.

The pharmacy's website included the required details, including its premises registration number, the SI's details including registration number, the pharmacy's opening hours and contact details. The website listed a selection of NHS and private services, providing people with helpful information.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not adequately monitor the temperature of its fridges so that it can't be sure the medicines kept in them are fit to be used. It effectively highlights its services to people so they can easily access them. It obtains its medicines from recognised suppliers. And it responds satisfactorily to drug alerts or product recalls. Team members know how to identify people supplied with high-risk medicines so 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 Pharmacy First, the New Medicine Service (NMS), the contraception service and seasonal flu vaccinations. The pharmacy also offered free deliveries to people who couldn't visit the pharmacy in person. There was a large sign in the entrance highlighting the pharmacy's services.

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 the barcode scanning used by the PMR system created an audit trail of each step in the dispensing process, identifying who had completed each step. Team members explained how the system had been set 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 SI explained that they checked the retrieval shelves every Sunday 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 dispensed in the company's neighbouring branch. Those premises acted only as a hub for assembling compliance aids for this pharmacy. The PMR systems were networked between the two branches so they could both view the records and ensure all the necessary checks could be made before dispensing any interim prescriptions.

Staff were aware of the risks involved in dispensing valproates to women in the at-risk group. The RP checked whether those in the at-risk group had long-term contraception in place and signposted them to their GP if necessary. They dispensed complete original packs and didn't obscure any warnings with their dispensing labels. They also made suitable checks when dispensing other high-risk medicines such

as methotrexate or lithium. The RP also knew to record any interventions on the PMR system.

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 as well as walk-in requests for the Pharmacy First service. Records were kept on the PharmOutcomes online platform. The RP confirmed that her own individual login enabled her to access the service and her own signed Patient Group Directions (PGDs) for the prescription only medicines (POMs) provided. But the signed PGDs for the regular pharmacists who worked there were not available during the inspection. The SI subsequently emailed them to the inspector. He highlighted that some people expected more from the service than they were able to provide, especially regarding the limited range of medicines they could supply.

There was a file containing details of the pharmacy's contraception service, whereby they could initiate a new supply of an appropriate oral contraceptive, depending upon the outcome of a consultation. The PharmOutcomes platform took them through the necessary steps, highlighting whether a blood pressure check should be made first. The service also enabled them to make further supplies if appropriate. Signed PGDs and declarations of competence were emailed to the inspector following the inspection.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance, Colorama, Sigma and Bestway. Unlicensed 'specials' were obtained from a variety of special suppliers. Routine date checks were seen to be in place, carried out on the last Wednesday of each month. One of the team members explained that those items due to expire within the following 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 sleeves attached to both fridges. But the records for the 'collection fridge' indicated maximum temperatures of 18 Celsius throughout August, and a maximum of 21.6 Celsius in July, compared with the expected range of between two to eight Celsius. Records for June were missing and those for May also indicated 21.6 Celsius. The records for the 'stock fridge' indicated a maximum of 18 Celsius on every day in August except for three when the maximum temperature was 17.9 Celsius. The maximum temperature in July was 19.9 Celsius throughout June with no records for July. The SI was unable to provide a satisfactory explanation for how this had been allowed to go on for so long and why nobody had brought it to either his or the responsible pharmacist's attention. The SI was advised to consider a backup means of measuring the fridge temperatures, and also to ensure all those tasked with checking them, fully understood how to do it, including how to reset the thermometer each time. Following the inspection, the SI provided the inspector with details of the remedial action taken, including contacting the manufacturer for instructions, training the staff and disposing of unusable stock. 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 were given to the pharmacist so they

could be appropriately recorded, and that there were no sharps present. People returning unwanted 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 a set of crown-stamped conical measures and suitable equipment for counting loose tablets and capsules. All the necessary equipment was available for the Pharmacy's services, including a blood pressure monitor and an otoscope. The consultation room was spacious, soundproof, and used for some of the pharmacy's services.

All computer screens were positioned so that they were not visible to the public and were password protected. NHS smartcards were in use, and team members were using their own NHS smartcards. The pharmacy made use of online reference sources such as the electronic medicines compendium and the BNF online.

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.