

Registered pharmacy inspection report

Pharmacy Name: Prime Pharmacy - Barnes, 198 Castelnau, Barnes,
LONDON, SW13 9DW

Pharmacy reference: 1041140

Type of pharmacy: Community

Date of inspection: 16/11/2023

Pharmacy context

This is an independently owned community pharmacy. The pharmacy is on a parade of local shops and businesses in Barnes in the London borough of Richmond-upon-Thames. It dispenses prescriptions. And it has a selection of over-the-counter medicines and other pharmacy related products for sale. It can provide medicines in multi-compartment compliance packs for people who need them.

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 adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future. The pharmacy has suitable written procedures in place to help ensure that its team members work safely. And, in general, the team understands and follows them. The pharmacy has insurance to cover its services. And its team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. But the pharmacy does not always complete all its records properly.

Inspector's evidence

The responsible pharmacist (RP) had worked part-time at the pharmacy for several years. A second part-time pharmacist covered the remaining shifts, with regular locums employed to cover any gaps. The team had a system for recording its mistakes. But it did not record them all. And it had not recorded any for the last seven months. The RP often worked alone. And she felt that she learned from her mistakes, even although she did not record them. And when she had a dispensing assistant to support her, she highlighted and discussed 'near misses' and errors as soon as possible with them to help prevent the same mistakes from happening again. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). And in response to several near miss mistakes with LASAs it had separated several of these products to different areas of the dispensary. It had done this to reduce the risk of selecting the wrong one. And while it was clear that the team discussed what had gone wrong. And it acted in response to its mistakes, it did not record what its team members had learned or what it would do differently next time. Team members did not always identify the steps they could introduce to their own procedures to help them improve. The pharmacy did not have a formal review process to identify and manage any trends. But the RP carried out an informal review on a periodic basis. The RP, and inspector discussed this and agreed that a more structured approach to recording and reviewing mistakes would help the team to monitor its learning and improvement more effectively.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its team members to follow. And they had read them. And they appeared to understand and follow them. The medicines counter assistant (MCA) was also a fully trained dispensing assistant (DA). And she consulted the RP when she needed her advice and expertise. And she asked appropriate questions before handing people's prescription medicines to them. Or selling a pharmacy medicine. She did this to ensure that people got the right advice about their medicines. The RP had placed her RP notice on display where people could see it. The notice showed her name and registration number as required by law. People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy also had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The team commented that, because of ongoing medicines shortages there had been some problems with ensuring continuity of prescriptions and supplies of medicines. But the team had worked closely with local surgeries to ensure that people did not go without essential medicines. And it arranged for alternatives when they received a prescription for an item that they could not get. It also tried to keep people's preferred brands of medicines in stock so that they did not have to wait

while the team ordered them. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its emergency supply records. And its controlled drug (CD) registers. It kept a record of its CD running balances. And a random sample of stock checked during the inspection matched the total recorded in the register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. And it generally kept it up to date. The pharmacy's private prescription records were also generally in order. But the pharmacy had a small number of emailed private prescriptions for which it had yet to receive the originals. And it had not kept an RP record for several years. Locum pharmacists had made a small number of records to record their shifts. And this was used for payment purposes. But regular pharmacists did not record when their duties began and ended as the law required. The inspector discussed this with the RP. And she agreed to obtain any outstanding prescriptions and ensure that they were obtained more promptly in future. The RP also agreed that all pharmacists should be reminded of their responsibilities to complete the RP record. And that this should be monitored to ensure that the record is kept as it should.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They shredded confidential paper waste as they worked. And the team kept people's personal information, including their prescription details, out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. But it had not had any concerns to report.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy trains its team members suitably for the tasks they carry out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

On the day of the inspection the pharmacy had two team members on duty, the RP and the MCA DA. The pharmacy was up to date with its prescription workload. And team members helped each other when they needed to. The MCA DA had worked at the pharmacy for some time and was an experienced team member. She worked closely with the RP and asked appropriate questions when people asked to buy a pharmacy medicine. She was observed asking these questions when someone asked to buy a brand of cough mixture. She did this to ensure that the cough mixture was the right one to treat their cough. And to ensure that it was appropriate for them to take. She was also observed to be independent when looking at patient medication records (PMR). So that she could give people the right information about the readiness of their prescriptions. And she handed their dispensed medicines out correctly, after she had confirmed their identity discreetly. But she was also seen to consult the RP when she needed her intervention, advice and expertise.

The pharmacy had a small close-knit team who worked regularly together. Team members did not have formal reviews about their work performance or formal team meetings. But they discussed issues as they worked. And they held occasional meetings when they needed to. They left notes for other when their shifts changed over. So that team members coming in knew what the issues and priorities were from the previous shift. Team members felt supported. And they felt they could discuss any concerns with the RP or superintendent (SI) as appropriate. The RP made day-to-day professional decisions in the interest of patients. And she felt that she could discuss concerns with the SI.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises provide an environment which is adequate for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was in an old building on a small parade of shops serving the local community. It occupied three levels, the shop floor level, a lower level down a small flight of stairs and a below ground, cellar level. Access to the pharmacy's lower levels were through a doorway from the shop floor to the side of the counter. The pharmacy had a consultation room which was on the first lower level. This meant that people using it had to be able to go down the flight of stairs safely. The pharmacy's staff facilities were also on this level. The below ground level had two rooms, one for staff use. And the other had storage facilities and a large desk for making up multi-compartment compliance packs. The main pharmacy area had a small retail area with seating for waiting customers. And a short pharmacy counter which was open on one side. The opening provided access to the dispensary and the area behind the counter for staff and authorised visitors. This area provided enough space to store counter medicines and the team had installed an additional open shelving rack to display medicines which in the past people had been less able to see. And it provided an added barrier to help keep completed prescriptions out of people's view.

The pharmacy had a compact dispensary. And so, it used its below ground cellar area for compartment pack dispensing. The main dispensary had a desk on one side. And dispensing benches on the remaining three sides which were used for most of the pharmacy's dispensing activities. And it had storage facilities above and below the benches. One of the dispensary's workstations was at a right angle to the retail space and the back of the medicines counter, so that team members in the dispensary could work undisturbed. But they could also see people waiting. The pharmacy generally kept its worksurfaces tidy and organised. The pharmacy team had a cleaning routine. And it cleaned its most used surfaces regularly. Team members cleaned floors periodically and they tried to keep them tidy. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy generally provides its services safely. It supports people with suitable advice and healthcare information. And it ensures that it supplies its medicines with the information that people need to take their medicines properly. The pharmacy team gets its medicines and medical devices from appropriate sources. And, in general, team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. But the pharmacy does not always do enough to ensure that it stores all its medicines in the appropriate packaging. And in the appropriate environment. And it does not always make all its services accessible for everyone.

Inspector's evidence

The pharmacy had information on its windows promoting its opening hours. The pharmacy's doorway had two steps up to the entrance and so it did not have step-free entry. And so, this, alongside the steps down to the consultation room meant that it would be difficult for people with mobility issues to access all services requiring a private consultation. This put limitations on the range and extent to which the pharmacy could provide services to people. And so it limited its range of services. And team members signposted people to other service providers where appropriate. But once inside the pharmacy its customer area was free of unnecessary obstacles. And the team could also order people's repeat prescriptions if required. And it had a delivery service. It prioritised the service for people who had no other way of getting their medicines.

The pharmacy used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It provided medicines in multi-compartment compliance packs for people living at home who needed them. And it labelled the packs with the required advisory information to help people take their medicines properly. It supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. And it labelled its compliance packs with a description of each medicine, including colour and shape, to help people, including other healthcare professionals, to identify them. But as part of its dispensing process the team assembled the packs in advance. And while team members kept prescriptions in baskets with compliance packs and with the packs of stock medicines used to dispense them, they did not always label the packs at the time. And several packs were found unlabelled. This meant that the packs and their contents were not clearly identifiable. The pharmacist gave people advice on a range of matters. And she would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP described how she would counsel at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. The pharmacy also knew to supply the appropriate patient cards and information leaflets each time. And to supply the medicine in its original packaging. The pharmacy offered a hypertension case finding service. The RP had referred several people to their GPs following a high blood pressure reading. And it kept appropriate records.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And it generally stored its medicines appropriately. Stock on the shelves and in drawers was generally tidy and organised. But a small number of stock medicines had been stored in a basket as loose strips or in plain white cartons with only the name of the medicine and its strength. This meant

that the medicines were not packaged with sufficient information to fully identify them. The pharmacy checked the expiry dates on all stock items regularly, but it did not keep records. The team identified and highlighted any short-dated items. And it removed any items with a less than a three-to-four-month expiry date from stock. It only dispensed them with the patient's agreement where they could use them before their expiry dates. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team generally stored its CD items appropriately. The team generally stored its fridge items appropriately. But the team did not read or reset its fridge temperatures. Instead, team members judged the temperatures by assessing how cold the fridge was when it opened them. So, the single set of temperatures recorded did not reflect the temperatures at which any of the medicines had been stored. The RP and the inspector agreed that the team must monitor fridge temperatures properly to ensure that the medication inside it was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it generally keeps them clean. The team uses its facilities and equipment to keep people's confidential information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. The pharmacy had a computer terminal with a patient medication record (PMR) system in the dispensary. And a non-PMR computer in the consultation room. It used these for its non-prescription services. Computers were password protected. Team members had their own smart cards. But occasionally they shared each other's. The inspector and team members discussed the importance of using their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions so that people's details were out of general view.

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.