General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Vigo Pharmacy, 7 The Bay, Vigo Village, Meopham, GRAVESEND, Kent, DA13 0TD

Pharmacy reference: 1032786

Type of pharmacy: Community

Date of inspection: 04/12/2019

Pharmacy context

The pharmacy is located in a small shopping precinct in a village. The nearest surgery is around a ten minute drive from the pharmacy. The pharmacy provides a range of services, including Medicines Use Reviews and the New Medicine Service. It supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. It receives around 80% of its prescriptions electronically. And the people who use the pharmacy are mainly older people.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It largely protects people's personal information and it seeks feedback from people who use the pharmacy. It generally keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. Team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included; some documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Not all standard operating procedures (SOPs) required by law were available at the pharmacy. The missing ones included 'the steps to be taken when there is a change of responsible pharmacist at the premises'. The missing SOPs may make it harder for the pharmacy team to know what the right procedures are. The pharmacist said that he would ensure that all the required SOPs were available and he would request that all team members read them and signed to indicate that they had understood them.

Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The dispenser explained that the pharmacist segregated the medicine involved so that he could discuss it with the person who had made the mistake if they were not working on the day that the mistake was noticed. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. There had not been any recent dispensing incidents reported to the pharmacy.

Workspace in the dispensary was largely free from clutter; there was enough clear workspace for dispensing. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The trainee medicines counter assistant (MCA) said that the pharmacy would open if the pharmacist had not turned up in the morning. She was aware the she should not hand out any dispensed items or sell any pharmacy-only medicines before the pharmacist had arrived. But she was not aware that she should not sell General Sales List medicines. The inspector reminded her what she could and couldn't do if the pharmacist had not turned up. The dispenser said that she would not carry out any dispensing tasks before there was a responsible pharmacist signed in.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. The pharmacist said that all necessary information was recorded when a supply of an unlicensed medicine was made. But there were none available at the pharmacy to inspect on the day of

the inspection. The private prescription records were not available to inspect on the day of the inspection. The pharmacist said that he had inadvertently taken them home. He confirmed that the private prescription records had been returned to the pharmacy following the inspection. The nature of the emergency was not routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacist said that he would ensure that the nature of emergency was recorded in the future. Controlled drug (CD) registers examined were filled in correctly. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) log was available but there was a large number of times when the log had not been completed. The pharmacist explained that the pharmacy had moved from a paper copy, to electronic and back to paper, but he had not made entries for all the times that the pharmacy was open. He said that he would ensure that one contemporaneous log was kept in the future. The right RP notice was clearly displayed.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. The pharmacist used his own smartcard to access the NHS electronic services. The pharmacist said that he would apply for a smartcard for the dispenser. Bagged items waiting collection could be viewed by people using the pharmacy. But people's personal information was not visible.

The pharmacy carried out patient satisfaction surveys; results from the 2017 to 2018 survey were available on the NHS website. Results showed that 100% of respondents were satisfied with the pharmacy overall. Results from the most recent 2019 survey were not available. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacist said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Some team members had undertaken some training but the trainee MCA had not yet. She could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. And they can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets. Team members are provided with some training to support their learning needs and maintain their knowledge and skills. But it could do more to ensure that team members are enrolled on accredited pharmacy courses in a timely manner.

Inspector's evidence

There was one pharmacist (superintendent), one trained dispenser and one trainee MCA working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The pharmacist said that the trainee MCA had been carrying out some dispensing tasks and was not enrolled on an accredited course for this. She had worked at the pharmacy for over three months and had been enrolled on an accredited counter course. The pharmacist explained that he would not allow her to do any dispensing until she was enrolled on a suitable course. Following the inspection, the pharmacist confirmed that the trainee MCA had not carried out any dispensing tasks since the inspection.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. The dispenser said that she was provided with some training, but this was not structured or on a regular basis. She said that the pharmacy received information from suppliers and she read this.

The pharmacist said that he felt able to take professional decisions. He explained that team members had informal ongoing performance reviews, but these were not documented. The trainee MCA said that she felt comfortable about discussing any issues with the pharmacist or making any suggestions. Information was usually passed on informally, but the pharmacist explained that there were meetings held every few months to discuss any issues, updates or changes to procedures. They also had regular reviews of any dispensing mistakes and discussed these openly in the team.

Targets were not set for team members. The pharmacist explained that he carried out the services for the benefit of the people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was not available; the room temperature on the day of the inspection was suitable for storing medicines. The pharmacist said that fans were used during the warmer months.

There were two chairs in the shop area for people to use. The dispenser said that she would offer people the use of the consultation room if they wanted to discuss something in a more private setting. Some bagged items were not kept secure. The pharmacist said that he would ensure that these were not accessible to people using the pharmacy in the future.

The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area. The window in the door was see-through. The pharmacist said that he would ensure that this was covered in the future so that people’s privacy was protected when using the room. Toilet facilities were clean and there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was a small stop up to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available.

The pharmacist said that he did not routinely check monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. This could make it harder for the pharmacy to know that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The trainee MCA was aware which prescriptions were only valid for 28 days. The pharmacist said that he would highlight these prescriptions in the future. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group. The pharmacy had the relevant patient information leaflets and warning cards available. And the pharmacist said that these would be provided when needed.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked around twice a year and this activity was sometimes recorded. Short dated items were not marked, but lists were kept for some short-dated items. There were several out-of-date medicines found with dispensing stock. The pharmacist said that he would ensure that a more reliable date checking routine was implemented.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were generally kept until the prescription was no longer valid. The pharmacist said that he sometimes contacted people to remind them about their uncollected medication. He confirmed that uncollected prescriptions would be returned to the NHS electronic system or destroyed in the pharmacy.

The pharmacist said that people who had their medicines in multi-compartment compliance packs had been assessed by their GPs to show that the packs were needed. Prescriptions for people receiving these packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that the pharmacy contacted people to see if they needed them when their packs were due. The

pharmacy kept a record for each person which included any changes to their medication. Dispensing labels were attached to the backing sheets and there was an audit trail to show who had dispensed and checked each pack. But the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. Medication descriptions were not put on the packs to help people and their carers identify the medicines and patient information leaflets were not routinely supplied. This could make it harder for people to identify their medicines and have up-to-date information about how to take their medicines safely. The pharmacist said that he would ensure that the packs were suitably labelled in the future and that the patient information leaflets were routinely supplied with them.

CDs requiring safe storage were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by the pharmacist when needed. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA via email. The pharmacist said that he actioned these, but no record of any action taken was kept. This made it harder for the pharmacy to show what it had done in response. The pharmacist said that he would keep a record of any action taken in the future.

The pharmacy did not have the equipment to be able to comply with the EU Falsified Medicines Directive. The pharmacist said that the pharmacy was likely to have the equipment in the near future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and clean. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were usually checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. But the temperatures had not been checked since 27 November 2019 as the thermometer needed new batteries. The pharmacist said that he had ordered replacements and these needed fitting into the thermometer. Following the inspection, the pharmacist confirmed that the thermometer was working and that the temperatures were consistently within the required range. The fridge was suitable for storing medicines and was not overstocked.

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.