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: 12/02/2024

Pharmacy context

The pharmacy is in a small shopping precinct in a village. It provides NHS dispensing services and the New Medicine Service. And it supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support.

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 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 not all met	4.3	Standard not met	The pharmacy does not always store its medicines securely. And it cannot show that its medicines requiring refrigeration are stored appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy largely identifies and manages the risks associated with its services. People can provide feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people. The pharmacy largely keeps its records up to date and accurate. And it generally protects people's personal information. The pharmacy doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy had some standard operating procedures (SOPs) available, but they had not been updated for several years. The pharmacist said that he would ensure that these were updated and that team members had signed to show that they had read, understood, and agreed to follow them. The dispenser knew that she should not hand out dispensed medicines or sell pharmacy-only medicines if the responsible pharmacist (RP) had not turned up. But she thought that she could sell medicines from the general sales list. The inspector reminded her what she could and couldn't do if there was no RP signed in.

The pharmacist explained that he would make team members aware if they made a dispensing mistake before the medicine had reached a person (near miss). And they would then be responsible for rectifying their own mistakes. The pharmacist said that there had been recent near misses, but these had not been recorded for a couple of months. He explained that he would encourage team members to record their own mistakes in future and the near miss record would be reviewed regularly for patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The dispenser said that there had been a recent dispensing error where the wrong type of medicine had been supplied to a person. The pharmacist had not been previously made aware of the error. He said that he would undertake a root cause analysis and complete an incident report form for it. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy's information leaflet.

Workspace in the dispensary was limited but it was largely free from clutter, and there was an organised workflow which helped staff to prioritise tasks and manage the workload. The pharmacy used baskets to help minimise the risk of medicines being transferred to a different prescription. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not recorded, and several pages did not have the headings completed. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The pharmacist said that a full CD running balance check was carried out at regular intervals, but this activity was not recorded. He said that he would keep a record of balance checks in future. The right RP notice was not displayed at the start of the inspection, but the pharmacist displayed his notice when prompted. The RP record was kept

electronically. But there were some days where the incorrect finish time for the RP had been recorded. And there were some days where there was no record to show who was the RP. The pharmacist said that he would contact the software provider to find out how to address this. The pharmacy had stopped using the handwritten private prescription record in 2018 and the pharmacist said that the pharmacy's computer system made a record in the electronic register at the time the prescription was entered. The pharmacist was not able to find the electronic private prescription record during the inspection. He said that he would contact the software provider to find out how to access this information. The pharmacist said that people were referred to NHS 111 if they needed an emergency supply of a prescription-only medicine.

Confidential waste was disposed of by a specialist waste company. Computers were password protected and the people using the pharmacy could not see information on the computer screens. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacist used his own smartcard to access the NHS electronic services, but the dispenser did not have her own card. The pharmacist said that he would request a smartcard for her. The pharmacy often kept paperwork with people's personal information longer than it needed to. The pharmacist made progress during the inspection to address this and said that he would ensure that people's personal information was disposed of appropriately when it was no longer needed.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The dispenser said that there had not been any recent safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The dispenser said that she had signposted people to the relevant authorities when needed and also to a local drop-in centre where people could access some assistance.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely and they largely do the right training for their roles. They are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can take professional decisions to ensure people taking medicines are safe. And they can raise concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There was one pharmacist (who was also the superintendent pharmacist) and one trained dispenser working during the inspection. The pharmacist said that a team member not working on the day of the inspection had been enrolled on a dispenser course around two years ago but had not completed it. He said that he would contact the course provider and enrol her on another course if needed. There was a trained medicines counter assistant (MCA) who was not working on the day of the inspection.

The dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of medicines containing pseudoephedrine. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She asked relevant questions to establish whether the medicines were suitable for the person they were intended for.

The pharmacist was aware of the continuing professional development requirement for revalidation. And he felt able to make professional decisions. He said that he had recently started the training for the Pharmacy First Service. And he would ensure that he had undertaken all the required training before offering the service. The dispenser said that she had also recently undertaken some training for the Pharmacy Quality Scheme. She explained that she had access to online training modules and could sometimes complete these when the pharmacy was quiet. And she said that the pharmacist gave her some pharmacy-related information leaflets and booklets on an ad hoc basis which she read.

The pharmacist and dispenser had worked together at the pharmacy for over 20 years, and they had a good working relationship. The dispenser said that she could discuss any issues with the pharmacist or make suggestions about the pharmacy. The pharmacist said that team members had ongoing informal performance reviews. The dispenser said that there were team meetings every two months, but information was usually passed on informally during the day. Targets were not set for team members.

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. But the pharmacy could do more to keep some areas tidy and free from clutter.

Inspector's evidence

The pharmacy was secured from unauthorised access. Toilet facilities were clean and there were separate hand washing facilities available. But some waste medicines were stored in the room. And this made it harder for the pharmacy to show that these medicines were being kept securely. 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 available, and the room temperature was suitable for storing medicines. There were two chairs in the shop area for people to use while they waited.

The pharmacy was bright, clean, and generally tidy. The consultation room was cluttered with boxes. The room was not kept secure when not in use and there was some patient information found in there. The pharmacist removed this during the inspection and said that he would ensure that patient information was not kept in the consultation room in future. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. And the room was accessible to wheelchair users, suitably equipped and well-screened.

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

Summary findings

The pharmacy cannot sufficiently demonstrate that it stores all its medicines appropriately or keep them secure. But overall, it generally manages its other services appropriately. People with a range of needs can access the pharmacy's services. And the pharmacy gets its medicines from reputable suppliers.

Inspector's evidence

There was step-free access 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.

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 dispenser knew how long these prescriptions were valid for but said that she would highlight these prescriptions in future. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But it did not currently supply valproate medicines to anyone in the at-risk group. He was not aware of the need for people in the at-risk group to be on the Pregnancy Prevention Programme. And he was not aware that people should receive these medicines in original full packs. He was not aware that the warning card could be removed from the medicine packaging to allow room to apply the dispensing label so that it didn't cover any of the warnings. He said that he would undertake some learning about the recent updated information regarding valproate medicines.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. But he didn't keep a record of any action taken, which could make it harder for the pharmacy to show what it had done in response. The pharmacist said that he would keep a record in future. Stock was stored in an organised manner in the dispensary. The pharmacist said that expiry dates were checked regularly but this activity was not recorded. There were no date-expired items found in with dispensing stock during a spot check and medicines were kept in their original packaging.

CDs were not always kept secure, and the pharmacy did not have a denaturing kit available for the safe destruction of CDs. The pharmacy had a register available to record CDs people had returned, but it had not been used for several years. The pharmacist said that he would use the register in future and record CDs at the time they were received into the pharmacy. The pharmacist said that he would order denaturing kits and ensure that returned and expired CDs were disposed of appropriately. Expired CDs were clearly marked and kept separated from dispensing stock. The pharmacist said that he would contact the CDAO and arrange for a destruction of the expired CDs. Following the inspection, the pharmacist confirmed that the returned CDs had been denatured.

The pharmacy used a domestic type of fridge to store medicines requiring refrigeration. The pharmacist could not recall the last time that the fridge temperatures were checked. And the thermometer in the

fridge was not working. The pharmacist said that he would order a thermometer and if the temperature was found to be outside the appropriate range. And he would contact the pharmacy's insurance company to ask what the appropriate action would be for the medicines in the fridge. Following the inspection, the pharmacist confirmed that he had contacted the pharmacy's insurance company and was awaiting their response. And he confirmed that there was now a working thermometer in the fridge.

The pharmacist had recently implemented a new system for dealing with part-dispensed prescriptions. A list of medicines owed was kept and the pharmacist used the prescriptions on the NHS electronic system as a reference when dispensing owed medicines. There were several part dispensed prescriptions found in various places in the pharmacy and some were older than five months. The pharmacist said that he would ensure that only one system was used to managing part-dispensed in future. '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. The dispenser said that uncollected prescriptions were checked regularly. Prescriptions were kept at the pharmacy until the prescription expired. And items were returned to dispensing stock where possible once the prescription had expired. The pharmacist said that this system would be reviewed, and people would be contacted after around four weeks to check whether they still needed the medicine.

The pharmacist said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. The pharmacy did not order prescriptions on behalf of people who received their medicines in the packs. Prescriptions for 'when required' medicines were not routinely requested. The pharmacist said that people requested prescriptions for these items if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication. The pharmacist said that an up-to-date record sheet was printed each time a pack was assembled. There were several old medication record sheets in the pharmacy which might make it hard to know which was the current one. The pharmacist said that he would keep only one printed copy of a person's medication record, and this would be updated with any changes. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. But the backing sheets were not attached to the packs, and this could increase the chance of them being misplaced. The pharmacist said that he would ensure these were attached to the packs in future. Medication descriptions were put on the packs to help people and their carers identify the medicines. But patient information leaflets were routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacist said that some people had said that they did not want the leaflets every time they received their medicines, and he would make a record on the person's medication record to reflect this.

The pharmacist said that the pharmacy made deliveries to people who were not physically able to get to the pharmacy themselves, and they did not have someone who could collect their medicines for them. The pharmacy had a book available to record signatures for these deliveries, but it had not been used since 2019. This could make it harder for the pharmacy to show that the medicines were safely delivered. The pharmacist said that he would use the book in future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy 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. Triangle tablet counters were available and clean. And a separate counter was marked for cytotoxic use only which helped avoid any cross-contamination. Up-to-date reference sources were available in the pharmacy and online. The weighing scales appeared to be in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.