

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: 28/08/2024

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. This was a reinspection of the pharmacy, following an inspection in February 2024 when it was found not to be meeting all the Standards for registered pharmacies.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It had made improvements since the previous inspection, and it now records and regularly reviews any mistakes that happen during the dispensing process. And it protects people's personal information well. People can provide feedback about the pharmacy. And it the pharmacy largely keeps its records up to date and accurate. Team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. Team members' roles and responsibilities were specified in the SOPs. Team members said that the pharmacy would not open if the pharmacist had not turned up in the morning. And they knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacy had made improvements since the previous inspection and near misses were recorded and reviewed regularly for any patterns. A recent dispensing error (a dispensing mistake which had reached a person) had occurred where the wrong strength of medicine had been supplied to a person. It had been recorded on a designated form and a root cause analysis had been undertaken. The complaints procedure was available for team members to follow if needed. The dispenser said that there had not been any recent complaints and she would refer any to the pharmacist.

Workspace in the dispensary was limited and it was cluttered during the previous inspection. But it was now free from clutter. 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. 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. The pharmacist said that he would refer people to NHS 111 if they needed a prescription-only medicine in an emergency without a prescription. The private prescription records were largely completed correctly, but the prescriber's name was not routinely recorded. The importance of maintaining complete records about private prescriptions was discussed with the pharmacist. The recorded quantity of one controlled drug (CD) item checked at random was the same as the physical amount of stock available. CD registers examined were filled in correctly. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was largely completed correctly. The RPs did not routinely complete the record when they finished their shift and there was a different pharmacist working the following day. The pharmacist said that he would remind them to complete the record properly in future.

People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. Computers were password protected and people using the pharmacy could not see information on the computer screens. And confidential waste was removed by a specialist waste contractor. The pharmacist used his own smartcard to access the NHS electronic services during the inspection, but the dispenser did not have her own card. She said that she was in the process of applying for one. The pharmacy had made improvements since the previous inspection, and it no longer kept people's personal information longer than needed.

Team members had completed training about protecting vulnerable people. The dispenser described potential signs that might indicate a safeguarding concern and she would refer any concerns to the pharmacist. She 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. And the dispenser said that would refer people to the local drop-in centre if appropriate.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. Team members do the right training for their roles. And they are provided with some ongoing training to help keep their knowledge and skills up to date. They can raise any concerns or make suggestions. And they can make professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist (who was also the superintendent pharmacist), one trained dispenser and one trainee dispenser working during the inspection. And the trainee dispenser had been enrolled on an accredited course since the previous inspection. There were contingency arrangements for pharmacist cover if needed. Team members worked well together and communicated effectively during the inspection to ensure that tasks were prioritised. And the pharmacy was up to date with its dispensing.

Team members appeared confident when speaking with people. And they asked relevant questions to establish whether an over-the-counter medicine was suitable for the person it was intended for. The trainee dispenser was aware of the restrictions on sales of medicines containing pseudoephedrine. She knew which medicines could be misused and said that she would refer to the pharmacist if a person regularly requested to purchase these medicines.

The pharmacist was aware of the continuing professional development requirement for revalidation. And he felt able to make professional decisions. He had recently completed training for the Pharmacy First service. The dispenser said that she was not provided with ongoing training on a regular basis, but she received pharmacy-related information on an ad hoc basis from the pharmacist. And she had access to some online training modules.

The dispenser said that she had a good working relationship with the pharmacist, and they had worked together at the pharmacy for over 20 years. Team members felt able to discuss any issues with the pharmacist as they arose, and they had ongoing informal performance reviews. 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. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured against unauthorised access. 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. And the room temperature was suitable for storing medicines. There was seating in the shop area for people waiting for services.

The pharmacy was bright and clean which presented a professional image. It had made improvements since the previous inspection and the dispensary and consultation room were now free from clutter. And patient identifiable information was no longer kept in the consultation room. Toilet facilities were clean and were now not used for storing pharmacy items. And there were separate hand washing facilities available. The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Principle 4 - Services ✓ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely. The pharmacy had made improvements since the previous inspection, and it now stores its CDs and medicines requiring refrigeration appropriately. And it now highlights prescriptions for higher-risk medicines so there is an opportunity to speak with people when they collect these medicines.

Inspector's evidence

There was a small step into the pharmacy. The dispenser explained that the pharmacy had a portable ramp which could be used if needed to help people access the pharmacy. Services and opening times were clearly advertised, and a variety of health information leaflets was available.

The pharmacist said that the local surgeries would not issue a prescription for a higher-risk medicine if the person needed to have a blood test done. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected these medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist explained that following the previous inspection, he had undertaken some learning about valproate medicines. And the pharmacy now supplied these medicines in their original packaging. And he would now refer people to their GP if they needed to be on the PPP and weren't on one.

The pharmacy had made improvements since the previous inspection with the way it stored its CDs, and these were now stored in accordance with legal requirements. And denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were now clearly marked and separated. And returned CDs were now recorded in a register and destroyed with a witness, and two signatures were recorded. The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacist explained the action the pharmacy took in response to any alerts or recalls received from the NHS and the MHRA. During the previous inspection the pharmacy was found to not be making a record about the action taken following an alert or recall. The pharmacist said that this was still not being done, but he would ensure that a record was kept in future.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was now recorded. There were no date-expired items found in with dispensing stock during a random spot check and medicines were kept in their original packaging. The pharmacy had made improvements since the previous inspection with how it stores its medicines requiring refrigeration. Fridge temperatures were now checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and it was not overstocked.

The pharmacy had previously kept uncollected items in the retrieval system until the prescription had expired. Since the previous inspection, the team had made an improvement and people were now contacted if they had not collected their items after around four weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. During the previous inspection, it was found that there was not a robust system to manage part dispensed prescriptions. The pharmacy now kept these in one place, and they 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. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The pharmacist said that people were referred from their GP if they needed to have their medicines in multi-compartment compliance packs. The pharmacy did not order prescriptions on behalf of people who received their medicines in multi-compartment compliance packs. It kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were now routinely supplied.

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 and triangle tablet counters were available and clean. 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 phone in the dispensary was portable so it could be taken to a more private area where needed. And the weighing scales and the shredder were in good working order.

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.