General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Vision Pharmacy, 108 Bridge Road, LEICESTER, Leicestershire, LE5 3QN

Pharmacy reference: 1034016

Type of pharmacy: Community

Date of inspection: 12/11/2019

Pharmacy context

This is a community pharmacy in a mixed residential and business suburb of Leicester. Most of the activity is dispensing NHS prescriptions and giving advice about medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own homes. Other services that the pharmacy provides includes prescription deliveries to people's homes, Medicines Use Reviews (MUR), New Medicine Service (NMS) checks, and seasonal flu vaccinations under both NHS and private patient group directions (PGDs).

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

The pharmacy mainly identifies and manages the risks associated with the provision of its services. The pharmacy adequately manages people's personal information. It knows how to protect vulnerable people. The pharmacy has some procedures to learn from its mistakes. But, because it doesn't routinely record its near misses it could be missing opportunities to improve the safety and quality of its services.

Inspector's evidence

The Responsible Pharmacist (RP) notice showing the name and registration number of the pharmacist in charge of the pharmacy was on display. It was a very scruffy notice which didn't present a professional image. The pharmacist replaced the notice. The notice was on a shelf behind some medicines which meant that the pharmacists name but not his registration number was clearly visible. The pharmacist moved the notice to make it more visible.

The pharmacy had a set of standard operating procedures (SOPs) which were next due a review in 2020. The SOPs had been read and signed by staff but not by the pharmacist who had been at the pharmacy since 2015. He said he would read and sign them. Some information in the SOPs, for example, references to the Royal Pharmaceutical Society of Great Britain and the Shipman Enquiry were no longer relevant.

The counter assistant understood her role. She was aware that she couldn't work in the dispensary. She knew the questions to ask to sell a medicine safely and when to refer a person to the pharmacist. She knew that most prescriptions had a six-month expiry date and she was aware that controlled drug (CD) prescriptions were valid for 28 days from the date of the prescription. She could recall some but not all CDs with a 28-day validity that were not stored in the CD cabinet. The pharmacist said that prescriptions were not highlighted but that he would introduce a procedure to highlight to staff if a bag of dispensed medicines contained a controlled drug.

The pharmacy was providing an NHS and a private flu vaccination service. Staff had been encouraged to remind people visiting the pharmacy about flu vaccinations and this had led to an increased uptake of the service. The pharmacy had an up-to-date private patient group direction (PGD) for flu vaccinations and training records were available. There was no record to show that the pharmacist had signed the NHS flu vaccination PGD to say he would comply with NHS guidance.

The pharmacy had a process for managing near misses, errors and incidents. The pharmacist explained that when a mistake was found during the final check the near miss was returned to the member of staff who had made the error for them to resolve. Reasons for the error were then discussed with the member of staff. The near miss was supposed to be recorded in the near miss log, but the pharmacist said this hadn't been done for some time. The last record in the near miss log was dated August 2018. The pharmacist had made some ad-hoc records since.

An audit trail was created through the use of 'dispensed by' and 'checked by' boxes on the medicine label. The final check was carried out by the RP. There were no initials in the 'dispensed by' and 'checked by' boxes on the three bottles containing dispensed methadone. The pharmacist said that he dispensed and checked methadone himself and had not yet signed the boxes. He said that he would change his practise to get a second check when dispensing methadone.

Records to support the safe and effective delivery of pharmacy services were legally compliant. These included the RP log, private prescription records and the CD register. CD running balances were kept. There were out of-date-stock and patient-returned CDs that required destruction. These items were separated from in date stock medicines. Patient-returned CDs were recorded in an appropriate register. There was one patient-returned CD that had not been entered in the register.

There was a complaints procedure in place; staff referred to the pharmacist to investigate if necessary. There was a patient information leaflet which gave details about how to complain. The customer satisfaction survey was on display on the NHS UK website. All of the people who had completed the survey were satisfied with the service provided.

Public liability and professional indemnity insurance were in place until the end of July 2020. Confidential waste was shredded. There was an information governance protocol in place. Computer terminals in the dispensary were positioned so that they couldn't be seen by people visiting the pharmacy. Access to the electronic patient medication record (PMR) was password protected. The pharmacist was aware of safeguarding requirements; there was guidance which had been read by staff with local contact details available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are suitably trained for the roles they undertake. Team members work well together, and they can raise concerns if needed. The team members receive some support in keeping their skills and knowledge up to date. But a structured programme for on-going training could enhance the training provided.

Inspector's evidence

The pharmacy displayed who the RP in charge of the pharmacy was. The RP record showed who the RP in charge of the pharmacy had been. During the inspection the pharmacy team managed the workload effectively. There was a pharmacist, a pharmacy technician and one trained counter assistant who had recently transferred from another branch of the company.

Staff said that they had regular informal conversations about their performance with one of the directors. They said they could raise issues or concerns when required. The pharmacist said that he gave informal training to staff and this included updates on changes in legislation or medicines and there were pharmacy magazines that the team could read. But there wasn't any company-wide training.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure and appropriately maintained. The pharmacy generally protects personal information. Some sound carries from the consultation room. So care is needed when using this room to prevent private conversations being overheard.

Inspector's evidence

The front door of the pharmacy was marked and had peeling paint. Some of the posters in the window were a little untidy. Overall the outside of the pharmacy didn't present a professional image. The internal pharmacy was clean and maintained to an adequate standard although the pharmacy looked as if it had not been refitted for some time.

The dispensary was small but reasonably well-managed for the services provided. There was adequate dispensing bench available for the assembly of medicines, but the dispensing bench was cluttered with other equipment such as cartons and dispensing bags which reduced the space to dispense. The dispensary was clean and there was a sink with hot and cold water.

The dispensary was an appropriate temperature for the storage of medicines. Medicines were also kept in a store room at the back of the dispensary. The temperature of the room had not been recorded since October 2019 but the temperature at the time of the inspection was appropriate. Lighting was sufficient.

A slightly small consultation room was available to ensure people could have more confidential conversations with pharmacy staff. But, the room wasn't sound-proof, so conversations could be heard in the public area. In the dispensary computer screens were set back from and faced away from the counter. Access to the PMR was password protected. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy mainly provides a safe service. The pharmacy gets its medicines and medical devices from reputable sources. It generally stores them safely. Staff understand the actions to take if any medicines or devices are not safe to use to protect people's health and wellbeing. Some people may not be getting all the information they need to take their medicines safely.

Inspector's evidence

The pharmacy was within a row of shops. There was a push-pull door and a step which meant that access for a wheelchair or those with mobility issues was more difficult. There was a pharmacy practice leaflet which advertised the opening hours and services provided. Hours and services were also advertised on the door.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label to identify who had carried out each task. The pharmacy also used baskets during the dispensing process to reduce the risk of error. There were separate areas for the assembling and checking of prescriptions.

The pharmacist said that most of the people were regular customers, so he had a good understanding of the medicines they were taking. He said that he tried to speak to all people who brought their prescription into the pharmacy to give them suitable advice. He said that areas he focused on included antibiotics, medicines for children and any medicines with special directions. Currently the team were highlighting flu vaccinations. He said that he spoke to people who were on higher-risk medicines such as warfarin but didn't highlight prescriptions that were waiting collection. He was aware of the advice to give to people who were taking sodium valproate. He had the information leaflets but didn't have any people in the at-risk group at the pharmacy. The pharmacist understood the signposting process and used local knowledge to direct people to other healthcare providers. The pharmacy was a Healthy Living Pharmacy but didn't currently have a healthy living display.

Medicines were mainly stored in their original containers on the shelf, fridge or CD cabinet as appropriate. On the shelves there were four brown bottles containing dispensed medicines. Three only had the name of the medicine and one also had the original expiry date. The label should have included the name of the medicine, the batch number and expiry date from the original pack and the date of assembly. The pharmacist said he would put the medicines in the waste container for destruction and would make sure the correct information was recorded. Records showed that medicines requiring cold storage were stored in the fridge between 2 and 8 degrees Celsius. The thermometer's current temperature was within range but the minimum was minus 4 degrees Celsius and the maximum 26 degrees Celsius. The pharmacist said that he didn't know how to reset the thermometer. He said he would find out how to reset the thermometer, check the fridge temperatures and take any appropriate action.

The pharmacy delivered medicines to people using an electronic system to record the delivery. The person who received the medicine was supposed to sign to confirm they had received it to provide a record of delivery. When records were checked the signatures looked similar which may show that it was the driver who was signing. The pharmacist said that he would make sure that the driver

understood the need to obtain signatures from the person receiving the medicine.

The pharmacy had a process to make sure that people who received their medicines in a multi-compartment compliance pack were supplied in a timely manner. Each person had a chart showing when in the day medicines were taken and the chart recorded any changes in their medicines. Labels on the compliance pack checked recorded the shape and colour of the medicine to allow easy identification. But patient information leaflets were not routinely sent every month. On the compliance pack checked the pharmacist had signed to show he had checked it, but the pharmacy technician hadn't signed to show she had dispensed it which created an incomplete audit trail. The pharmacy started supplying medicines in a compliance pack following a request from local surgeries. They weren't currently periodically reviewing people to see if a pack was still suitable, but the pharmacist said they would look to start doing so.

Date checking was carried out every three months with records in the dispensary. Short-dated stock was highlighted. Out-of-date medicines were put in yellow waste bins; a patient-returned CD register was in place. The pharmacy recorded the date of opening on all liquid medicines. Only recognised wholesalers were used for the supply of medicines.

The pharmacist was aware of the procedure for drug alerts. The pharmacist printed out alerts but didn't sign them or date them which would make it more difficult for the pharmacy to show what action had been taken if there was a future query. The pharmacy had the equipment to introduce the Falsified Medicines Directive but had not yet had training in the procedures. The pharmacist said that he would speak to the superintendent to arrange training.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services that it offers. But it needs to make sure that the fridge is able to store medicines at the right temperatures. It maintains its equipment and facilities adequately.

Inspector's evidence

The pharmacy used crown marked measures for measuring liquids. Separate measures were used for CDs. The pharmacy had a range of up-to-date reference sources. CDs were stored securely. The fridge thermometer showed maximum and minimum temperatures that were outside of the required range. Stickers showed that electrical portable appliance testing had been last carried out in November 2019.

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.