General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Vision Pharmacy, 3A & 3B Defiant Close, Hawkinge, Folkestone, Kent, CT18 7SU

Pharmacy reference: 9012235

Type of pharmacy: Community

Date of inspection: 19/08/2024

Pharmacy context

The pharmacy is on a parade of shops in a largely residential area. It provides NHS dispensing services, the New Medicine Service, flu vaccinations and the Pharmacy First service. And it has a Post Office counter. The pharmacy supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. And it supplies medicines to a large number of people who live in care homes. The pharmacy had relocated around six months prior to the inspection and this was the first inspection of the new premises.

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 identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. 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.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs). The pharmacist explained that the pharmacy had recently started using a different computer system and she was in the process of updating the SOPs. She said that once they were updated, team members would sign to show that they had read, understood, and agreed to follow them. The dispenser said that the pharmacy would open if the pharmacist had not turned up in the morning. He knew which tasks should not be undertaken if there was no responsible pharmacist (RP) signed in. And the trainee medicines counter assistant (MCA) knew that she should not hand out dispensed items or sell any pharmacy-only medicines if the pharmacist was not in the pharmacy.

The dispenser explained that 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. And the dispenser said that the pharmacy's computer system alerted team members if the wrong medicine was scanned during the dispensing process. He explained that this new system had helped to minimise the chance of the wrong medicine being dispensed. Near misses were recorded but they had not been reviewed for patterns. The pharmacist said that dispensing errors, where a dispensing mistake had reached a person, would be recorded electronically and a root cause analysis would be undertaken. But there had not been any recent dispensing errors. The complaints procedure was available for team members to follow if needed. The dispenser said that he would refer any complaints to the pharmacist. And the pharmacist said that there had not been any recent complaints.

A bar code was printed on the dispensing labels, and this could show who had been involved with the dispensing process. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription.

The pharmacy had current professional indemnity insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The pharmacist said that people were referred to make a request for an emergency supply via NHS 111. And a record of any supplies was made electronically and included the nature of the emergency. Controlled drug (CD) running balances were checked at regular intervals and the 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 private prescription records were largely completed correctly, but the appropriate date on the prescription and the prescriber's details were not routinely recorded. The importance of maintaining complete records about private prescriptions was discussed with the pharmacist.

Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. Confidential waste was removed by a specialist waste contractor, computers were password protected and people using the pharmacy could not see information on the computer screens.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people. The dispenser described potential signs that might indicate a safeguarding concern and said that he would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. And team members do the right training for their roles. 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), one trained dispenser, one trainee pharmacy technician, one trainee dispenser and one trainee MCA working during the inspection. The pharmacist said that holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. The pharmacy was up to date with its dispensing and team members communicated effectively during the inspection to ensure the workload was well managed.

The trainee MCA appeared confident when speaking with people. She explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care. And she was aware of the restrictions on sales of medicines containing pseudoephedrine. Team members asked relevant questions to establish whether a medicine was suitable for the person it was intended for.

The pharmacist was aware of the continuing professional development requirement for professional revalidation. And she felt able to make professional decisions. She had completed declarations of competence and consultation skills for the services offered, as well as associated training. And she had recently undertaken some training about dengue fever and the vaccination against it. The dispenser said that team members were not provided with ongoing training on a regular basis, but they did receive some. He said that the pharmacist passed on pharmacy-related information to team members on an ad hoc basis.

Team members felt comfortable about discussing any issues with the pharmacist. And the dispenser said that they had informal ongoing performance reviews with the pharmacist. He said that the pharmacist allocated tasks in the morning, depending on the priority of the workload. Targets were not set for team members. The pharmacist said that services provided for the benefit of the people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was secured against unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. 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 pharmacy-only medicines were kept behind the counter. Air conditioning was available, and the room temperature was suitable for storing medicines.

There was seating in the shop area for people waiting for services. The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. 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. And people with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was step-free access into 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 pharmacy could produce large-print labels for people who needed them.

There were signed in-date patient group directions available for the relevant services offered. And consultations for the Pharmacy First service were recorded electronically. Bagged items were scanned on the pharmacy's computer system prior to being handed out. The dispenser explained that the system would show if a prescription was no longer valid, and these would not be handed out. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said they checked CDs and fridge items with people when handing them out. 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 described how they would refer people to their GP if they needed to be on the PPP and weren't on one. And she explained that they pharmacy supplied these medicines in their original packaging. The pharmacist said that the local surgeries would not issue a prescription for a higher-risk medicine if a person had not had a recent relevant blood test. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. And items due to expire within the next six months were marked. The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacy received drug alerts and recalls from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The fridge was suitable for storing medicines and was not overstocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. CDs were 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 clearly marked and separated. Returned CDs were recorded in a register, destroyed with a witness, and two people's details were recorded.

The dispenser explained that uncollected prescriptions were checked regularly and any items remaining uncollected after around two months were returned to dispensing stock where possible. And the

prescriptions for these items were returned to the NHS electronic system or to the prescriber. 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.

The pharmacist said that she carried out assessments to show that they needed their medicines in multi-compartment compliance packs. The pharmacy ordered prescriptions on behalf of people who received their medicines in the packs if they could not do this for themselves. These were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. And the packs were suitably labelled. The care homes ordered prescriptions for their residents, and these were supplied with medicine administration charts. The care homes sent the pharmacy lists of prescriptions requested and this was cross-referenced against the prescriptions received. The pharmacy made the care homes aware if a prescription had not been received as requested.

Deliveries were made by a delivery driver. The dispenser said that the driver left a card at the address asking the person to contact the pharmacy to rearrange delivery if they were not at home when a delivery attempt was made. And he said that all undelivered medicines were returned to the pharmacy before the end of the working day. The pharmacy did not currently obtain people's signatures. The dispenser said that the delivery driver provided details of the prescriptions they had delivered, and these were marked as being 'handed out' on the computer system.

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

The pharmacy had up-to-date reference sources available. The blood pressure monitor had been in use for less than one year. The pharmacist said that this would be replaced in line with the manufacturer’s guidance. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. The pharmacy had suitable equipment for measuring liquids. The otoscope was cleaned regularly, and disposable tips were used for each examination.

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.