

Registered pharmacy inspection report

Pharmacy Name: Seaview Pharmacy, Pier Road, SEAVIEW, Isle of Wight, PO34 5BL

Pharmacy reference: 1032553

Type of pharmacy: Community

Date of inspection: 11/05/2021

Pharmacy context

A community pharmacy located in the small village of Seaview on the Isle of Wight serving an elderly population and tourists. The pharmacy opens six days a week. It sells a range of healthcare products, including over-the-counter medicines. It dispenses people's prescriptions. It offers the NHS New Medicine Service. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy provides winter flu vaccinations. People can also now collect coronavirus (COVID-19) home-testing kits from the pharmacy. The pharmacy also has a post office counter situated within it.

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

The pharmacy adequately identifies and manages the risks associated with its services. Including learning from mistakes to help them to try and stop them happening again. They can explain what they do, what they're responsible for and when they might seek help. They know how to protect vulnerable people. And they keep people's private information safe. People using the pharmacy can provide feedback to help improve the pharmacy's services. The pharmacy keeps the records it needs to by law. And it has appropriate insurance to protect people if things do go wrong.

Inspector's evidence

The pharmacy had completed a risk assessment of the impact of COVID-19 on the pharmacy and its services. And, as a result, it had temporarily suspended some of its face-to-face services. The pharmacist had undertaken an occupational COVID-19 risk assessment for team members to help identify and protect those at increased risk. Team members were self-testing for COVID-19 twice weekly using lateral flow tests. They wore face masks to help reduce the risks associated with the virus. And they washed their hands or used hand sanitisers regularly. The pharmacy had received a COVID safe inspection from the local council.

The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. These were last reviewed January 2020 and all staff had read and signed them to confirm their understanding. Members of the pharmacy team used baskets to separate people's medicines being assembled and prepared, and to help them prioritise the dispensing workload. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by the pharmacist. The pharmacy had a process to record and review dispensing errors and near misses. The pharmacist discussed individual learning points with team members when they identified a mistake. They reviewed their mistakes periodically to help spot the cause of them. And they shared learning from these reviews with each other. So, they could try to stop the same types of mistakes happening again for example taking great care with similar products such as aspirin gastro resistant and dispersible formulations.

The pharmacy displayed a notice that informed people who the responsible pharmacist (RP) was at any time. Staff were clear on their roles and responsibilities and explained that they wouldn't hand out prescriptions or sell medicines if the pharmacist wasn't present. The pharmacy had a complaints procedure and a process for obtaining feedback about the pharmacy. The pharmacy was generally asked to complete a satisfaction survey once a year. But a survey wasn't done last year due to the pandemic. Feedback seen and displayed online was generally very positive. The pharmacy had appropriate insurance arrangements in place for the services it provided. The pharmacy kept an electronic record to show which pharmacist was the RP and when. The regular pharmacist wasn't sure how to log out as the RP but undertook to resolve this with the software provider. The pharmacy maintained controlled drug (CD) registers, which were in order. The pharmacist checked and maintained running balances of the CD stock levels and those balances checked were in order. The pharmacy had not recently supplied any special or unlicensed medicines, but the pharmacist was aware of the records they needed to maintain for such supplies. The pharmacist maintained an electronic private prescription record which was in order.

The pharmacy had procedures in place for protecting people's personal information. The pharmacy had

arrangements in place to make sure confidential waste was shredded and disposed of securely. The pharmacist had completed the centre for pharmacy postgraduate education CPPE level 2 safeguarding training and the staff were aware of the need to take appropriate action to safeguard vulnerable people. The pharmacy was also part of the domestic abuse ask for ANI (action needed immediately) scheme.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has sufficient staff to deliver safe and effective care although both are currently fairly new in post and still undertaking training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback and know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist (the RP) and two full time apprentice trainee dispensers. The pharmacy also employed a full-time delivery driver as well as someone who assisted with deliveries as required. Occasionally in the past one of the drivers would assist in the shop. However currently the pharmacist stated that this was not happening and, she undertook to ensure that the driver was placed on the appropriate training if she returned to assist in any additional role in the future.

The two trainees worked well together under the direct supervision of the pharmacist, who also closely supervised the supply of over-the-counter medicines and advice provided by them. A team member described the questions they would ask when making over-the-counter recommendations and the advice they would provide when selling OTC medicines of abuse for example those containing codeine.

The two dispensers were currently completing their level 2 training programme and had regular reviews with their external apprenticeship tutors remotely over Zoom and with the pharmacist. They were encouraged to ask questions and familiarise themselves with new products. Some regular dedicated work time was provided to the trainees to complete their training.

The pharmacy doesn't set targets and members of the pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. One of the trainees had recently reorganised the eye drops into separate baskets to reduce the risk of errors selecting products for prescriptions.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is small but currently provides an adequate and secure environment for people to receive healthcare. However, the dispensary area does require some refurbishment work and tidying to create additional space. The pharmacy has a room where people can have private conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy was very small and had limited workspace. It had a small dispensary and small retail area. During the pandemic patients were being seen one at a time close to the doorway and there was a good circulation of air through the building. There were markings on the floor and signage reminding people of the need to socially distance. Currently patients were being served close to the door and only one person was being let into the pharmacy at a time, there were markings on the floor and signs reminding people of the need to socially distance. Despite the limited space team members tried to maintain social distancing whilst working.

The pharmacy was set out on separate levels and there was limited workbench space available, particularly when assembling compliance aids this could potentially increase the risk of errors. The dispensary shelves were tidy and clean, however the workbenches were cluttered and waste cardboard boxes were in need of clearing from outside the rear door. The general decoration of the pharmacy was dated and in need of refurbishment, although the front retail area had been decorated and some improvements made in recent years. The pharmacist had planned to refurbish and increase the space for the dispensary area and had obtained quotes for the work. However, this had been put on hold due to the pandemic. The pharmacist gave an assurance that she would progress improvements to increase the available dispensary space and improve/ update the dispensary area over the coming months.

The pharmacy also had a consulting room which was suitable for the services it offered and if people needed to speak to a team member in private. The pharmacy had hot and cold running water and members of the pharmacy team were responsible for keeping the pharmacy's premises clean.

Principle 4 - Services ✓ Standards met

Summary findings

Pharmacy services are accessible, managed and safely delivered. The pharmacy delivers prescription medicines to people's homes where they are unable to collect directly from the pharmacy themselves. Pharmaceutical stock is appropriately obtained, stored and supplied. Where a medicinal product is not fit for purpose, team members take appropriate action. And they dispose of people's waste medicines properly too.

Inspector's evidence

The pharmacy counter and consultation room were on the lower floor and had wheelchair access if required. The pharmacy had a notice that told people when it was open and provided a delivery service for house-bound patients. The pharmacy team worked together to highlight when the pharmacist needed to speak to a patient about the medication they were collecting, such as a high-risk medicine, or if other items, such as a CD and a refrigerated product, needed to be added. The pharmacist was aware of the valproate pregnancy prevention programme and had carried out an audit to identify any patients in the risk group to ensure that they were appropriately counselled. The pharmacy offered a delivery service to people who couldn't attend its premises in person. This meant that the delivery person and the people they were delivering to could keep their distance from each other.

The pharmacy provided the Discharge Medicines Service working with the local hospital to help ensure the appropriateness of care when patients were discharged from the local hospital. The pharmacy also dispenses some medicines in multicompartiment compliance aids (blister packs) for those who may have difficulty managing their medicines. In addition, the pharmacy provided the Community Pharmacy Consultation Service and the Pharmacy Collect Service providing COVID-19 lateral flow test kits. The pharmacy used authorised wholesalers to obtain its pharmaceutical stock. The pharmacy team checked the expiry dates of medicines at regular intervals. It recorded when it had done these checks. And it marked products which were soon to expire to reduce the chances of it giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. The pharmacy kept its out-of-date, and patient-returned, CDs separate from in-date stock. And the pharmacist kept a record of the destruction of patient-returned CDs. The pharmacy had procedures for handling the unwanted medicines people returned to it. These medicines were kept separate from stock and were placed in a pharmaceutical waste bin. The pharmacist had a process for dealing with alerts and recalls about medicines and medical devices. And the pharmacist described the actions she took, and records maintained when she received a drug alert.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services offered. These are used in a way that helps protect patient confidentiality and dignity.

Inspector's evidence

The pharmacy had markings on its floor and a barrier in place to control the number of people entering the pharmacy and to help people keep apart. The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had a range of clean glass measures for use with liquids. It had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had refrigerators to store pharmaceutical stock requiring refrigeration. And the pharmacist regularly checked and recorded the maximum and minimum temperatures of each refrigerator. The pharmacy restricted access to its computers and patient medication record system using passwords and smartcard access. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. The pharmacy had a cordless telephone system. So, its team could have confidential conversations with people when necessary.

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.