

# Registered pharmacy inspection report

**Pharmacy Name:** Pier Avenue Pharmacy, 85-87 Pier Avenue, Clacton-on-Sea, Essex, CO15 1QE

**Pharmacy reference:** 9012239

**Type of pharmacy:** Community

**Date of inspection:** 20/05/2024

## Pharmacy context

This community pharmacy is located on a busy high street in the town of Clacton-on-Sea in Essex. It provides a variety of services including dispensing NHS prescriptions and the New Medicine Service (NMS). It also provides the Pharmacy First service and travel vaccinations through patient group directions (PGDs).

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

Overall, the pharmacy manages the risks associated with its services well. And its team members record and review any dispensing mistakes so they can learn and improve from these. The pharmacy keeps all the records it needs to by law. It has appropriate insurance arrangements in place. And the pharmacy handles people's private information safely.

### Inspector's evidence

The correct responsible pharmacist (RP) notice was displayed in a prominent position in the pharmacy. There was a range of standard operating procedures (SOPs) in the pharmacy which were available electronically and had been read by all team members. The SOPs were up to date. Team members were able to explain their roles and responsibilities within the pharmacy. And they also knew what activities they could and could not do in the absence of an RP. Near misses (dispensing mistakes which were spotted before a medicine left the pharmacy) were recorded on paper log sheets in the pharmacy in a good level of detail. The RP said he discussed any near misses with the team member involved and the team also had regular meetings to discuss near misses. Dispensing errors (mistakes which had reached a person) were recorded electronically in more detail. The RP said a meeting would also take place to discuss any errors that occurred. However, the RP also said there had not been a dispensing error since the pharmacy had opened.

Complaints and feedback could be submitted in several different ways. People could complain online via email and the team confirmed that any complaints or feedback about the pharmacy could also be given in person or via a phone call and would be actioned in the same way. Complaints were usually actioned by the RP but could be escalated to the superintendent pharmacist (SI) if necessary. Contact details for the pharmacy were available on the pharmacy's website.

Confidential material was shredded on site as soon as it was no longer needed. No confidential material was found in the general waste bin. And no confidential information could be seen from outside the dispensary. The RP confirmed that he had completed level three safeguarding training with the Centre for Pharmacy Postgraduate Education (CPPE). He was also the nominated safeguarding lead and had details of local safeguarding contacts should a safeguarding issue arise.

The pharmacy had current indemnity insurance. Balance checks were carried out regularly for controlled drugs (CDs), and records seen in the CD register were made in accordance with the law. A random check of a CD showed that the quantity in stock matched the running balance in the register. Records seen about private prescriptions dispensed were complete with all entries seen having the required details. The RP record was also complete with all entries seen having a start and finish time. Records about unlicensed specials were complete with all entries seen having the name of the person for whom the medicine was for and the date of dispensing. The pharmacy did not routinely do emergency supplies for people and would usually refer them to their GP or to the NHS 111 service.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to manage its workload effectively. And team members do the right training for their roles. They do some ongoing training to keep their knowledge and skills up to date. And team members feel comfortable about raising any concerns they have.

### Inspector's evidence

The pharmacy team consisted of the RP, two dispensers and two counter assistants. The RP confirmed that the pharmacy had enough team members to manage the workload and the pharmacy was up to date with dispensing. All team members had either completed or were in the process of completing an appropriate training course for their role, with an accredited training provider. The team did some ongoing training in the pharmacy on an ad-hoc basis, usually when a new medicine or service was being provided by the pharmacy. The RP said that team members had regular informal reviews with the SI to monitor their progress. Team members said they had no concerns about raising any issues and would usually go to the RP first but could raise a concern with the SI if necessary. The RP confirmed the team was set some targets relating to some pharmacy services provided but the RP said that these did not affect the team's ability to provide a safe and efficient service.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean and tidy and provides a safe and appropriate environment for people to access its services. People can have a conversation with a team member in a private area. And the pharmacy is kept secure from unauthorised access.

### Inspector's evidence

The front fascia of the pharmacy was in a good state of repair and was modern and professional looking. The shop floor was clean and professionally presented and it had chairs for people waiting to access the pharmacy's services. Pharmacy-only (P) medicines were stored securely behind the counter. The dispensary area was clean and tidy and had plenty of floor and desktop space for the team to work in. It had a sink for preparing liquid medicines which was kept clean. The room temperature and lighting of the pharmacy were adequate. There was a staff toilet with hot and cold running water and handwash available. The pharmacy had two consultation rooms for people who wished to have a conversation in private. They allowed for a conversation at a normal level of volume to be had without being heard from the outside. The rooms were a good size, were kept clean and could be locked when not in use. The pharmacy was kept secure from unauthorised access.

## Principle 4 - Services ✓ Standards met

### Summary findings

On the whole, the pharmacy provides its services safely and stores its medicines appropriately. The pharmacy can cater to people with different needs. And the team takes the right action in response to safety alerts to help ensure people get medicines and medical devices which are fit for purpose.

### Inspector's evidence

The pharmacy had step-free access via a manual door. It was able to cater for people with different needs, for example by printing large-print labels for people with sight issues. There was plenty of space for people with wheelchairs and pushchairs to access the dispensary counter. The dispensary had separate areas for dispensing and checking medicines, and baskets were used to separate prescriptions and reduce the chance of prescriptions getting mixed up. Checked medicines seen contained the initials of the dispenser and checker and this provided an audit trail.

The pharmacy provided a delivery service for people who had difficulty collecting their medicines from the pharmacy. The delivery driver used an electronic device with people's details to keep a record of deliveries. The pharmacy also had an electronic record of deliveries. If there was a failed delivery, the medicines would be returned to the pharmacy and a note put through the door with information about arranging a redelivery. For CD deliveries, an ID check and extra signature was required.

The pharmacy used stickers to highlight prescriptions that contained a high-risk medicine, a CD or an item requiring refrigeration. The RP confirmed that he always handed out high-risk medicines and that people received the appropriate counselling for their medicines.

The pharmacy obtained its medicines from licensed wholesalers and invoices were seen to confirm this. CDs requiring safe custody were stored securely. Team members confirmed that prepared medicines awaiting collection were checked regularly to reduce the chance of any expired prescriptions being accidentally given out. The pharmacy had two fridges for storing temperature sensitive medicines. Fridge temperature records showed that temperatures were checked regularly, and records seen were within the appropriate ranges. The current maximum temperatures of both fridges were found to be out of range during the inspection. However, the thermometers on the fridges were reset and then showed temperatures within the required range. Expiry date checks were completed monthly and a random check of medicines on the shelves revealed no expired medicines. The pharmacy also recorded the date liquid medicines were opened, so the team could assess if these were still suitable to supply. Safety alerts and recalls were received electronically via email and actioned accordingly, and alerts were archived after actioning.

Team members were aware of the risks of sodium valproate, and the RP knew what to do if a person in the at-risk category presented at the pharmacy. Team members knew where to apply a dispensing label to a box of sodium valproate so as not to cover any important safety information. They were aware about the recent guidance change with regards to supplying sodium valproate in the original pack.

The pharmacy had patient group directions (PGDs) for the Pharmacy First Service and for providing travel vaccinations. The PGDs seen were signed and in date. And the RP had completed the necessary training for the Pharmacy First Service. The pharmacy also had access to an appropriate anaphylaxis kit

in the consultation room for anyone who had a reaction to the vaccination. This was in date and fit for use.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the appropriate equipment to provide its services safely. And it protects people's privacy when using its equipment.

### Inspector's evidence

The pharmacy computers had access to the internet allowing team members to access any online resources they needed. Computers were password protected and faced away from public view to protect people's privacy. Team members were observed using their own NHS smartcards. The pharmacy had cordless phones so conversations could be had in private. The electrical equipment had been safety tested in the past but was now overdue; the RP said he would discuss this with the SI. The pharmacy had a blood pressure monitor in the consultation room and the team confirmed that it was new and so did not currently require replacement or recalibration. The pharmacy also had access to an otoscope for provision of the Pharmacy First service. There were appropriately calibrated glass measures for measuring liquid medicines. And tablet triangles for counting tablets, with a separate one for counting cytotoxic medicines such as methotrexate.

### 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.