

Registered pharmacy inspection report

Pharmacy Name: Allcures Pharmacy, 19 Lampits Hill, Corringham,
STANFORD-LE-HOPE, Essex, SS17 9AA

Pharmacy reference: 1031391

Type of pharmacy: Community

Date of inspection: 29/11/2022

Pharmacy context

The pharmacy is in a supermarket in a residential area. The pharmacy is part of a group of pharmacies. As well as dispensing NHS prescriptions the pharmacy provides flu vaccinations and offers a delivery service.

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's working practices are generally safe and effective. The pharmacy mainly keeps the records it needs to by law so that medicines are supplied safely and legally. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members respond appropriately when mistakes happen during the dispensing process. But the pharmacy may be missing opportunities to improve its services further as reviews of these events for patterns or trends hasn't happened in recent months.

Inspector's evidence

Standard operating procedures (SOPs) were available and team members had read and signed SOPs which were relevant to their roles. Team roles were defined within the SOPs. The responsible pharmacist (RP) had made local amendments to some SOPs. The RP had restarted working for the company in August 2022 and said that SOPs had moved online but he had not yet been able to access these. The RP was unsure if new team members had read SOPs as the pharmacy had recently had a high turnover of staff.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were recorded by team members on a log as they occurred. Completed near miss record sheets were seen during the inspection. The RP was trying to get the new join to get into the habit of recording her near misses. Most commonly occurring near misses related to the formulation. As a result of past mistakes, the different strengths of cyclizine had been separated on the shelf and the RP tried to order medicines with different packaging to avoid picking errors. Patient safety reviews had been completed previously each month during which near miss records and any dispensing errors were looked at to identify any trends or patterns with changes made accordingly. The pharmacy had not completed any reviews recently and the RP planned to restart. Dispensing errors were investigated, a record was made, and a copy of the record was forwarded to head office. To help reduce the number of errors when it was busy the RP tried to ensure that three people including the RP were involved in the dispensing and checking process. The RP tried to ensure that another team member double checked his work or if he had to self-check, he would take a mental break between dispensing and checking. The pharmacy had also created an allocated checking bench to help distinguish between the different steps.

A correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure. Where possible the RP tried to handle any complaints in store. In some instances, complaints were escalated to head office.

Records about private prescriptions, emergency supplies, controlled drug (CD) registers, unlicensed medicines dispensed, and RP records were generally well maintained. However, some pharmacists were not routinely signing out of the RP record. CDs that people had returned were recorded in a register as they were received. A random check of a CD medicine quantity complied with the balance recorded in the register.

Assembled prescriptions were stored in the dispensary and people's private information was not visible to others using the pharmacy. An information governance policy was available and this was reviewed by head office. Relevant team members who accessed NHS systems had smartcards. The RP had access to Summary Care Records (SCR) and consent to access these was gained verbally. Confidential paperwork and dispensing labels were segregated and sent to the head office branch for shredding.

Pharmacists had completed level two safeguarding training and some team members had also completed level one training. Contact details for safeguarding boards were available but the RP preferred to check for details online to ensure they were up to date.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to dispense and supply its medicines safely, and they work effectively together and are supportive of one another. Team members are given some ongoing training to keep their knowledge and skills up to date.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, a trained dispenser, and a locum dispenser. A medicines counter assistant and trainee dispenser were off work at the time of the inspection, and both had started working at the pharmacy recently. The pharmacy had recently decreased their opening hours. All team members who had been present at the previous inspection had left and the RP and dispenser had recently come back to work at the pharmacy. The RP explained that there had been some problems recruiting staff and there had been at least three people who had started working and then left shortly after. The RP thought that the pharmacy was now in a better place and the new members of staff who had joined were likely to stay on. The RP felt that if staff were fully trained there would be sufficient staff. The pharmacy was behind with their dispensing. At the time of the inspection, the team members were dispensing and checking walk-ins to ensure people who came to the pharmacy were able to collect their medicines.

Staff performance was managed by the RP. Company policy included completing appraisals; the RP had completed these with both the new joins and regular team members. The RP gave team members verbal feedback. Team members looked through pharmacy magazines during their lunch and the RP also briefed them on any changes as well as anything he had read that related to pharmacy activities. Representatives from different companies also briefed the team about their products. New team members were due to be enrolled on formal training courses. The RP had spoken to the head office team about enrolling them on programmes.

As the team was small, things were discussed as they arose. Zoom meetings were held monthly with the team at head office and sometimes the team from head office visited the pharmacy. There were no targets, but pharmacists were encouraged to provide services, there was some pressure to provide services, but the RP said that this did not affect his professional judgement.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was situated at the back of a supermarket. The pharmacy was separated from the supermarket by glass frontage which had a lockable door. General sales medicines were kept outside of the pharmacy, and these were sold through the supermarket tills. The pharmacy was clean and organised. There was ample workspace which had been allocated for different tasks. Cleaning was carried out by team members. A clean sink was available for the preparation of medicines.

The pharmacy had a large clean consultation room which was easily accessible. The room allowed a conversation at a normal level of volume to take place inside and not be overheard. There were some folders stored on a shelf which contained confidential information and some paperwork; the RP described that people were not left unaccompanied in the room and he planned to put the paperwork away once he had finished. The room temperature was adequate for providing pharmacy services and storing medicines safely. Air conditioning was available to help regulate the temperature. The premises were secure from unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

Overall, the pharmacy provides its services safely. People can access the pharmacy's services. It orders its medicines from reputable sources and largely manages them properly. And it takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy was easily accessible, it was situated at the back of a supermarket at street level and had double doors. Aisles were wide and allowed easy access to the pharmacy. Services were appropriately advertised to patients. Team members knew what services were available and described signposting people to other providers where needed. A delivery service was offered to those people who were unable to access the pharmacy.

Prescriptions were received electronically, then printed out and labels were processed and placed into one of two baskets depending on the number of items on the prescription. These were dispensed by a dispenser and left for the RP to check. The RP described how he always got a second check if he had dispensed a prescription or took a mental break in between each step. The team had designed the dispensary in a way to ensure there was a smooth workflow when the pharmacy had been refitted. Dispensed and checked-by boxes were available on labels, and these were routinely used. Baskets were used to separate prescriptions, preventing transfer of items between people. There were several baskets containing prescriptions awaiting checks, the RP explained that the system had been down at the surgery the day before the inspection which meant the pharmacy had then received a large number of prescriptions when the system was restored.

The RP was aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. The RP always handed out prescriptions for sodium valproate. Booklets and warning labels were available which were used. Methotrexate was stored in a separate basket. Additional checks were carried out when people collected medicines which required ongoing monitoring. The RP usually made a note of the INR on people's electronic record, however, he described not having done so over the past few weeks due to the issues with staffing. Prescriptions for schedule 4 CDs were annotated with the expiry date.

Multi-compartment compliance packs were managed by the hub store. The pharmacy acted as a collection point for people and some people's packs were delivered from the store. If people had any issues with their packs, they usually contacted the pharmacy and were signposted to the hub store.

Deliveries were carried out by a designated driver. Signatures were not obtained when medicines were delivered, and this was to help infection control. The pharmacy had delivery record sheets and the driver used an application to audit these. If someone was not available medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. Medicines were organised on shelves in a tidy manner. Fridge temperatures were monitored daily and recorded. Records seen showed that the temperature were within the required range for the storage of medicines. CDs were held securely.

Expiry date checks were carried out monthly by team members who worked on Saturday. These team members were new and were due to be enrolled on the MCA course. The RP provided an assurance that he would ensure only suitably trained team members would complete the date checking in the future. Short-dated stock was highlighted. Previous date-checking matrices were available for the dispensary, but these had not been updated. No date-expired medicines were found on the shelves checked. Out-of-date and other waste medicines were kept separate from stock and were generally stored securely and then collected by licensed waste collectors. Drug recalls were received via email from head office. Dispensers also had access to the pharmacy's email account. The RP also received these independently. Drug recalls were actioned and notification had to be sent back to head office once this was done.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean.

Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. Equipment was clean and ready for use. A medical fridge of adequate size was available. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. Blood pressure monitors were available; both were brand new, and the RP had recorded the dates on them for when they were first used.

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.