

Registered pharmacy inspection report

Pharmacy Name: Alconbury Chemist, 1 Bell Lane, Alconbury, Huntingdon, Cambridgeshire, PE28 4DU

Pharmacy reference: 9010858

Type of pharmacy: Community

Date of inspection: 23/10/2023

Pharmacy context

This community pharmacy is located at the front of a convenience store in the centre of a village in Cambridgeshire. Its main activity is dispensing NHS prescriptions, many of which it delivers to people's own homes. It supplies medicines in multi-compartment compliance packs to a substantial number of people who need help managing their medicines. And it sells a small range of medicines over the counter. The pharmacy is currently offering the seasonal flu vaccination service on an appointment-only basis.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy doesn't have a robust system to monitor and learn from mistakes that its team members make during the dispensing process.
		1.3	Standard not met	Team members do not all know what they can and cannot do when there is no pharmacist present in the pharmacy.
2. Staff	Standards not all met	2.2	Standard not met	Some pharmacy team members are not doing the appropriate training for the roles they undertake.
3. Premises	Standards not all met	3.1	Standard not met	There is insufficient clear space to prepare multi-compartment compliance packs safely. And the consultation room does not present a professional image to people receiving services.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy cannot show that it prepares multi-compartment compliance packs safely.
		4.3	Standard not met	The pharmacy cannot show that it stores medicines requiring refrigeration at the right temperatures. And medicines are not always kept in appropriately labelled containers.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy doesn't adequately manage all the risks associated with its services. It doesn't have a robust system to monitor and learn from mistakes that its team members make during the dispensing process. Some team members are not on the right training for their roles. And they do not fully understand the tasks that can only be undertaken when there is a pharmacist present. Furthermore, the lack of available space makes it difficult for its team to work in a safe way. However, the pharmacy team members can refer to recently reviewed written procedures which explain how to carry out various tasks. And they keep the records that are needed by law.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs) in the pharmacy. These included SOPs about safeguarding vulnerable adults and children, management of controlled drugs, dispensing and checking prescriptions, preparing multi-compartment compliance packs, and selling medicines over the counter. The SOPs had been reviewed during 2023 and had mostly been signed by members of the pharmacy team to provide an audit trail that team members had been trained on them. In a small number of cases, the SOPs had not been signed by all the team members to whom they applied.

There was an audit trail created during the dispensing process to show which members of staff had been involved in dispensing and checking prescriptions. And baskets were used to keep prescriptions for different people separate. The pharmacist present, who was working full-time at the pharmacy, explained that she would point out dispensing mistakes to team members when she found them at the accuracy checking stage. Many of these were said to be down to team members trying to work too quickly. But the pharmacy rarely recorded these incidents, known as near misses, currently due to difficulties managing the workload. There were two entries in the near miss record from September 2023, but the pharmacist said most of the multi-compartment compliance trays she checked had mistakes that needed to be corrected; these events had not been recorded. This made it harder for the pharmacy to identify any patterns or trends and put in place ways to reduce the number of mistakes being made. The pharmacist understood how dispensing mistakes which were not corrected before leaving the pharmacy should be recorded and reported. But she wasn't aware of any that had happened since she had started working as a responsible pharmacist (RP) at the pharmacy two months previously.

A team member, when asked, could explain the restrictions on the sales of certain medicines which could be misused or over-used, including pseudoephedrine products and painkillers containing codeine, and when to refer queries to the pharmacist. The pharmacy did not sell codeine linctus over the counter. There was an SOP that referred to the absence of an RP. This had been reviewed in June 2023 and had been signed by most of the team. However, when asked, team members said they would hand out dispensed medicines that had been checked, even if the pharmacist wasn't present.

The pharmacy had current professional indemnity and public liability insurance. There was information telling people how they could make a complaint about the pharmacy on the pharmacy's website and in its practice leaflet. The pharmacy clearly displayed a notice showing who was the responsible

pharmacist (RP) and this was correct. There was also a record kept about the RP. This record was largely complete though there were three gaps over the last two months. Records about private prescriptions were kept in a book and those viewed were complete. Controlled drugs (CD) registers were available. The CD records viewed were largely complete and the recorded stock agreed with the physical amount on hand for the two records checked. The last recorded balance check had been completed in October 2023 but the previous one had been in February 2023. The extended time interval between balance checks could make it harder to investigate any discrepancies promptly. The pharmacist could not find a record about patient-returned CDs but there were none present at the time of the visit. They agreed to ask the pharmacy owner about its whereabouts so they could make a prompt record about patient-returned CDs if any were accepted in the future.

Confidential information was largely protected by the pharmacy. Confidential waste was separated from other types of waste and the team members said it was taken for destruction by the pharmacy owner. Access to patient records was password protected and the pharmacist was using their own smartcard to access the NHS spine. Details on prescriptions could not be seen from the shop floor. The pharmacist explained how they removed or protected patient information in the consultation room should they bring anyone into the room for services or private conversations.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy's team members are not all doing the required training for the tasks they undertake. And they aren't clear about the restrictions on what can happen when there is no pharmacist present. This means the pharmacy cannot demonstrate adequately that its services are always provided safely. But its team members can discuss issues and get help from the responsible pharmacist if needed.

Inspector's evidence

At the time of the inspection, there were two members of staff plus the RP present. The two staff members had joined the pharmacy around two months and seven months previously. Both were involved in selling medicines over the counter and dispensing prescriptions. However, neither of them had been enrolled on accredited courses for these activities. There were a further two members of staff who were not present; they were said to be on dispenser training courses. The RP had qualified during the summer and had been in post as an employed pharmacist at the pharmacy for around two months. The pharmacy owner sometimes worked at the pharmacy but was not present during the inspection. The pharmacy had lost a trained dispenser earlier in the year and was in the process of recruiting additional staff to help with dispensing and checking prescriptions.

The RP was doing their best to manage the workload and was limiting their activities to dispensing and checking prescriptions and organising prescription deliveries that were due to take place that day. They explained vaccinations were largely by appointment so they had sufficient time to remove any patient sensitive information from the consultation room. They also provided evidence of a plan they had created showing the multi-compartment compliance packs that were due to be prepared and ready for people to have that week. However, they were also aware that the assistants were sometimes rushing to complete work and this meant there were mistakes occurring on most compliance packs that then needed to be amended which was creating additional workload.

Team members said they would raise any concerns with the RP and said they could also ask them about any queries relating to the pharmacy's services. There was a company weekly newsletter which included clinical updates as well as information about how the pharmacy was performing in relation to certain targets. Targets did not appear to impact the RP's ability to exercise their professional judgement.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy's premises are very small and there is insufficient clear dispensing and storage space to deliver all its current services safely. The appearance of its consultation room does not present a professional image to people.

Inspector's evidence

The pharmacy premises were at the front of a convenience store and had limited retail space of their own. There were shutters to secure the pharmacy when the rest of the store remained open. Pharmacy medicines were kept behind the medicine counter so that their sales could be supervised adequately. And there was a small range of medicines which people could self-select, close to the counter. There was also a chair near the counter that people waiting for services could use.

The dispensary was behind the counter and was a galley style. It had adequate lighting, and the ambient temperature was suitable for storing medicines. It was also reasonably clean. But there was virtually no clear dispensing bench space available for the staff to use as most of it was covered with multiple stacks of baskets with prescriptions waiting to be checked. This included the area around the sink and workspaces in the consultation room.

A small consultation room was situated just behind the medicine counter. This was very cluttered and appeared to be used largely for additional dispensing space and storing waste medicines. There was some seating in the room for when people received vaccinations. But the room did not present a professional image in its current state and access could be a problem if a person collapsed in the room. There were also patient names and addresses visible on some of the waste medicines stored in this room.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy tries to support housebound people and those who need additional help in managing their medicines. But it cannot show that it prepares multi-compartment compliance packs safely. It does not always make sure that medicines are stored in suitable and appropriately labelled containers. And it cannot show that medicines requiring refrigeration are always stored at the right temperatures. However, the pharmacy gets its medicines from reputable sources.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. There was some health information literature about self-care displayed in the pharmacy counter area. The pharmacy delivered medicines to people who could not visit the pharmacy in person. It didn't currently keep a record about the medicines that it delivered to people. This was said to be due to staffing problems and lack of time. However, the RP was trying to introduce some means of tracking deliveries that were due to go out so there was some form of audit trail.

The pharmacy provided medicines in multi-compartment compliance packs to a large number of people who needed this help to remember when to take their medicines. This work had increased since other local providers had stopped providing this service. Following an assurance visit by an inspector in July 2023 due to concerns about how compliance packs were dispensed, the pharmacy had introduced making records about changes on a person's patient medication record so information about these was readily available to pharmacists carrying out accuracy checks. But there were ongoing issues identified relating to this service. Some of the team members involved in preparing these packs were not on any accredited dispenser training and there were multiple mistakes being made during the dispensing process. There was insufficient clear dispensing bench space to prepare these packs safely. And the quantities on the backing sheets for some packs viewed did not reflect the actual contents of the packs. However, patient information leaflets were routinely supplied, and the packs were sealed as soon as they were prepared to reduce risk.

The RP understood the safety concerns and advice that needed to be provided to people about valproate-containing medicines. They also knew about supplying these medicines in the manufacturer's original container, so people received the right information and alerts. The pharmacy didn't currently dispense any valproate-containing medicines in compliance packs; the need to do a risk assessment should this be considered in future was discussed.

Stickers were used to highlight prescriptions for CDs so checks could be made that the supply could still be made. Checks were made with people when first supplying higher-risk medicines such as methotrexate to make sure people understood the dose they were to take and side effects to be aware of. But there was no formal process to make sure people were routinely counselled on subsequent supplies. So, the pharmacy could be missing opportunities to give people all the information they need to take their medicines safely.

The pharmacy got its medicines from licensed suppliers. Medicines for dispensing were stored on shelves in the dispensary and waste medicines were stored in designated bins. But there was one

example found where capsules had been removed from their original blister pack and placed in an unlabelled plain tablet bottle. There were several cartons found which contained loose tablets which should have been in blister strips, with no indication of when the medicines had been de-blistered. And there were multiple overstuffed cartons which contained mixed batches and medicines from different manufacturers. These seemed to have come about as result of mistakes or unwanted items used dispensed into compliance packs. One of the team members explained how they carried out date checks, but they did not keep any record about this activity. This could make it harder for the pharmacy to be sure that all its stock is checked regularly. However, when checked, there were no date-expired medicines found amongst in-date dispensary and over-the-counter stock. The team members accepted they could improve their records for date checking and said they would try to introduce a way of tracking this activity.

Medicines that required refrigerated storage were kept in the pharmacy's two fridges and these provided ample storage for the stock held. There was no evidence of ice build-up. The current temperature at the time of the inspection of the larger fridge was 4.5 degrees Celsius. But the pharmacy could not check the current temperature of the smaller fridge or its maximum and minimum temperature range. And team members did not know how to reset the maximum and minimum temperatures on the larger fridge to make sure the records kept accurately reflected the actual temperature ranges. The records often showed the temperatures ranging between 4 and 8 degrees Celsius, including on the day of the inspection, but the actual range showing on the thermometer on that day was from 2.8 to 16.2 degrees Celsius.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. But it cannot demonstrate that both of its fridges are storing medicines at the right temperature.

Inspector's evidence

The pharmacy had suitable equipment to count and measure medicines. This included counting triangles and validated glass measures. The equipment was clean. It also had the necessary equipment available to respond to an anaphylaxis reaction to a flu vaccination. There were cordless phones in the dispensary meaning that staff could move out of earshot of people in the shop area to have private phone conversations. Computer screens containing private information could not be viewed by the public and access to the patient medication records and summary care records was protected by passwords and smartcards. The pharmacy had sufficient refrigerated storage for the quantity of stock and dispensed items it carried. However, it could only monitor the maximum and minimum temperature ranges of one of the two fridges in use.

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.