General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, 108 Rodway Road, Patchway, BRISTOL, Avon, BS34 5PG

Pharmacy reference: 1028711

Type of pharmacy: Community

Date of inspection: 29/01/2020

Pharmacy context

This is a community pharmacy in a shopping area on the north-west outskirts of the city of Bristol. Most people who use the pharmacy are elderly. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy supplies a few medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines.

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

The pharmacy's working practices are generally safe and effective. The team members ask people for their feedback and use this to improve services. The pharmacy is appropriately insured to protect people if things go wrong. It mainly keeps the up-to-date records that is must by law. The team members know how to protect vulnerable people. But, they could be better at recording and learning from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team identified and managed most risks. Dispensing errors and incidents were recorded, reviewed and appropriately managed. The last error had been a form error involving Symbicort. A full root cause analysis had been done and the staff had been trained on the various forms of the inhaler. Near misses were recorded but insufficient information was documented to allow any useful analysis, such as a recent error with loratadine. It was documented that this was the wrong drug but no other information was recorded. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. General trends could be identified but this was not documented as being done.

The dispensary was extremely limited in size. There was just one working bench about 2m by 1m. The areas allocated to the assembly and the checking of prescriptions were approximately 0.5m by 1m each. These were not clearly separated and several baskets were stored on top of one another. This increased the risk of errors. In addition, the pharmacy had wholesaler dealer authorisation (WDA) from the Medicines and Healthcare products Regulatory Agency (MHRA). There was very little space for normal dispensing activities and the staff all said that having to deal with the wholesale activities further impacted on the already very small space. There was a clear audit trail of the dispensing process and all the 'dispensed by' and 'checked by' boxes on the labels examined had been initialled.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions, were in place and these were reviewed every two years, or sooner, if necessary, by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. A NVQ2 trainee dispenser said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. A qualified dispenser was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Ella One and referred requests for these to the pharmacist.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, 100% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback about providing healthy living advice. The pharmacist said that, as a result of this, he proactively offered advice, such as asking people who wanted a sugar-free medicine, if they were diabetic. And, if so, he or his staff provided them with advice.

Public liability and indemnity insurance, provided by the National Pharmacy Association (NPA), valid until 30 April 2020, was in place. The responsible pharmacist log, controlled drug (CD) records, including

patient-returns, emergency supply records, specials records, fridge temperature records and date checking records were all in order. Private prescriptions were recorded electronically and a couple seen did not include the address of the prescriber.

An information governance procedure was in place and the staff had also completed training on the general data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential waste paper information was shredded. No conversations could be overheard in the room that was used for consultations. But, this room also contained assembled multi-compartment compliance aids. Most of the compliance aids, previously assembled by the pharmacy, had been transferred to another branch. The pharmacist said that he hoped that the remaining few compliance aids, those containing CDs, would also soon be transferred, when the appropriate storage arrangements in the hub branch had been made. He also hoped that the room would be appropriately fitted as a consultation room.

The staff understood safeguarding issues and had read the company's procedures for the safeguarding of both children and vulnerable adults. The pharmacist had also completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely, especially since the recent removal of most of the compliance aids to another branch. Those team members who are in training are well supported by their manager. And, the whole team are comfortable about providing him with feedback. But, the team members are not doing regular on-going learning and so they may not be aware of recent any recent developments.

Inspector's evidence

The pharmacy was in a shopping area on the north-west outskirts of the city of Bristol. They mainly dispensed NHS prescriptions with the majority of these being repeats. A few domiciliary patients received their medicines in multi-compartment compliance aids (see under principle 1 and 4).

The current staffing profile was one pharmacist (the manager), one full-time NVQ2 qualified dispenser, one part-time NVQ2 trainee and one part-time medicine counter assistant (MCA). The manager had a staff rota to ensure that the trainee dispenser or MCA were usually working with him and the full-time dispenser. The part-time staff had limited flexibility to cover unplanned absences, due to child-care commitments. The staff said that they believed that company was undergoing a re-structure and so they were not sure if any holiday would be covered. This made it difficult for them to plan ahead. In addition, a newly employed member of staff said that she had been employed following a telephone interview. She had had no face-to-face interview. She said that the pharmacy manager had been very supportive and was currently putting her through an induction programme but that this had not been initiated by the higher management.

The pharmacist said that the last six months had been difficult. Since July 2019, he had lost 25 hours a week of staff support, including a pre-registration student who had not been replaced. He did say that the removal of most of the compliance aids to a hub branch should ease this situation. The pharmacist held monthly one-to-one meetings with his staff, but the staffing situation over the previous six months had made it difficult for him to do formal appraisals. The staff did read seasonal literature and also the monthly healthy ‘living topics’ but they were not signed up to any regular on-going learning. The pharmacist said that he planned to give the newly appointed trainee, dedicated learning time for her course. The pharmacist said that all learning was documented on his continuing professional development (CPD) records.

The staff seen all said that they felt well supported by their immediate manager and felt able to raise any issues with him. They held regular meetings, at least monthly. The pharmacist reported that he was set overall targets, such as for Medicine Use Reviews (MURs). He only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitable for the current services it provides. But, it is small with limited workspace. The team members do their best to keep the available space tidy and organised. The pharmacy has a room for private conversations but, this contains assembled medicines. And, the room is not signposted as a consultation room. This means that some people may not know that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was small with limited bench space. The pharmacy had WDA from the MHRA (see under principle 1). This placed the already limited space, under further pressure. The inspector spoke to the Superintendent about this. She gave assurance that she would review this. The premises were clean.

The room that was used for private consultations was the room that used to be used for the assembly, checking and storage of the compliance aids. Most of these had been transferred to a hub branch, but the pharmacy still assembled those compliance aids that contained CDs. The room was not signposted as a consultation room. It was long and narrow with shelving on the walls to accommodate the compliance aids. It did not easily lend itself to a suitable area for private consultations without some alterations. The pharmacy computer screens were not visible to customers. The telephone was cordless and any sensitive calls were taken out of earshot.

The temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

Most people can access the services the pharmacy offers. But, some people with specific mobility needs, may have difficulty entering the pharmacy. The pharmacy manages its services effectively to make sure that they are delivered safely. The team members make sure that people have the information that they need to use their medicines properly. The pharmacy gets its medicines from appropriate sources. And, it stores and disposes of them safely. The team members make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but no bell on the front door alerting staff to anyone who may need assistance entering the pharmacy. The staff could access an electronic translation application for use by non-English speakers. The pharmacy could print large labels for sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), the New Medicine Service (NMS), sexual health, the Community Pharmacy Consultation Service (CPCS) and supervised consumption of methadone and buprenorphine. No seasonal flu vaccinations were currently offered. The staff were aware of the services.

The pharmacist had completed suitable training for the provision of sexual health services, including the provision of the free NHS emergency hormonal contraception service. He had also done training on the new CPCS scheme but currently there was no computer in the room that was used for private consultations.

A few substance misuse patients had their medicines supervised and a few took their medicines home. There was a dedicated folder for these patients where any relevant information was kept. The supervised patients were offered water or engaged in conversation to reduce the likelihood of diversion.

A few domiciliary patients received their medicines in compliance aids. These all contained CDs. It was planned that these few would be transferred to the hub branch when they had the appropriate storage facilities. The pharmacy had a clear dispensing audit log for the compliance aids that they currently assembled. All changes or other issues were recorded on the patient's electronic prescription medication record (PMR). These were referred to at the checking stage. The assembled compliance aids were stored tidily but in the room that was also used as a consultation room.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. Interventions were seen to be recorded on the patient's prescription medication record. Green 'see the pharmacist' stickers were used. The pharmacist and the staff were clearly very well known to their patients. The pharmacist was seen to counsel all 'walk-in' patients. He also routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. International normalised ratios (INR) levels were asked about. The pharmacist also counselled patients prescribed amongst others, antibiotics, new drugs, any changes and complex dosages. CDs and insulin were checked with the patient on hand-out. The staff were aware of the sodium valproate guidance relating

to the pregnancy protection programme.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Potential non-adherence or other issues were mainly identified during MURs. The pharmacist reported that he gave advice during MURs about the correct timings of medicines, such as taking levothyroxine 20 minutes before breakfast and with water and not with a drink containing calcium.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, Lexon and Phoenix. Specials were obtained from Quantum Specials. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. But, there were a large quantity of patient-returned CDs and some out-of-date CDs. These were clearly labelled and separated from usable stock but were occupying valuable space in the cabinet. The pharmacist said that in the previous six months he had not had enough time to destroy the patient-returned CDs. He gave assurance that this would be done as soon as possible. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 14 January 2020 about Zapain. The pharmacy had none of the affected batches in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services its provides. And, the team members make sure it is clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 100ml). There were two tablet-counting triangles and one capsule counter. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken out of earshot. Confidential waste information was shredded.

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.