General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, 116 High Street North, DUNSTABLE, Bedfordshire, LU6 1LN

Pharmacy reference: 1028827

Type of pharmacy: Community

Date of inspection: 11/07/2022

Pharmacy context

The pharmacy is in a town, close to a surgery. It provides NHS and private prescription dispensing mainly to local residents. The pharmacy provides a supervised consumption service for people treated by the drug and alcohol team.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not always register its team members on training courses appropriate to their roles.
3. Premises	Standards not all met	3.4	Standard not met	The premises are not always kept secure from unauthorised access.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not always store its medicines safely or securely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has some issues around security, medicines storage, and training, but it otherwise manages the risks associated with its services adequately. Pharmacy team members generally keep people's private information safe. The pharmacy largely keeps its records up to date. But some records are not always made accurately, which could make them less able to be relied upon. The pharmacy does not always record and review its dispensing mistakes. And this could mean that team members are missing out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were issued by the company. The SOPs covered the services that were offered by the pharmacy. However the staff did not confirm that they had read them and were not sure where they were kept. The procedures said the team members should log any mistakes in the dispensing process in order to learn from them. Dispensing mistakes which were identified before the medicine was handed to a person were called 'near misses'. Team members said that they sometimes logged near misses but did not discuss trends and learning from them. There were no near misses recorded for June or July. Medicines which looked similar or sounded alike were separated on the shelves.

The pharmacy conspicuously displayed the correct responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. When asked, the pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice when needed.

The pharmacy team recorded private prescriptions and emergency supplies on the computer, but the details of the prescriber were not always recorded accurately. The controlled drugs registers examined were up to date and legally compliant. The team did regular checks on the recorded balance and actual stock of controlled drugs to ensure that there were no missing entries.

Information produced by the computers and labelling printers was not visible to people in the retail area. Computers were password protected to prevent unauthorised access to confidential information. Other patient-identifiable information was kept securely away from the public view. Confidential waste was separated into bags and disposed of by a licensed waste contractor. Access to the NHS database was not robust, with staff seen to share their access cards when not using the computers, the staff were reminded of the reasons not to share their cards, and gave an assurance that they would not do so in the future. The pharmacist had undertaken level 2 training on safeguarding and the whole team had done internal training on the subject. There were local telephone numbers for the safeguarding boards available for use if needed. The pharmacy had current professional indemnity and public liability insurances.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always enrol its staff on the appropriate training courses in a timely manner. However, it has enough staff to provide its services.

Inspector's evidence

The pharmacy was run by locum pharmacists. The pharmacist present said that she did not manage the pharmacy but had been present on most days for the past few months. The staff were up to date with the dispensing of prescriptions.

There were two staff working in the pharmacy on the day of the inspection. Neither had been enrolled on appropriate training courses. One worked mainly on the counter and had started in April 2022, and was also involved in attaching labels to picked items and bagging of medicines once they had been checked by the pharmacist. The other worked as a dispenser and had started work at the pharmacy around seven months ago. The pharmacist was reminded of the need for formal training of all staff working with medicines, and she said that she would tell Head Office. The person working as a dispenser was involved in dispensing multi-compartment compliance packs and explained she had been shown what to do by the trained dispenser. Dispensing the packs is a higher-risk dispensing process. And as the team member had not been registered on an appropriate course, it was harder for the pharmacy to show that the team member had the right skills to dispense the packs safely. There was another, appropriately trained, dispenser in the team, who was not present during the inspection.

The staff said that they had been visited by the operations manager during the previous week, but explained that they had only received emails from the field team in the months prior to this.

Principle 3 - Premises **Standards not all met**

Summary findings

The premises are not always kept secure from unauthorised access. The pharmacy is generally clean, but some areas are cluttered. And the pharmacy has a room which can be used for private conversations, but it could do more to keep the room tidy and able to be used.

Inspector's evidence

The pharmacy counter was to the side of the premises. It was clean and tidy. There was a consultation room, which was mostly used for storage and which had a missing light bulb, making it very dark, so it could not be used for professional consultations. The dispensary had been extended into the shop area, meaning that there was adequate space for dispensing. There were three benches, one used for checking, one for walk-in prescriptions, and another for dispensing multi-compartment compliance packs and unpacking goods orders. The dispensary appeared cluttered. There were adequate hygiene facilities, with a dispensary sink as well as a staff kitchen.

There was a door to the side of the dispensary, which led outside. At the time of the inspection was left open. There was a grill which could be used to secure it, and still allow the passage of air, but this was not being used. And so, the premises were not appropriately secure from unauthorised access when the pharmacy was open. When the pharmacy was closed, it was able to be appropriately secured.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always store its medicines securely or in a safe way. Its other working practices are generally safe, and it gets its medicines from reputable sources. The pharmacy takes the right action in response to safety alerts, to help make sure that people get medicines and medical devices that are safe to use.

Inspector's evidence

Access to the pharmacy was level from the pavement. People were signposted to other services available locally when required.

The use of baskets helped to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. Computer-generated labels included relevant warnings. Some people were being supplied their medicines in multi-compartment compliance packs. Some packs had been dispensed on the previous Friday and had been left unsealed over the weekend. This increased the chance of them being knocked and medicines moving within the packs. And as the packs were unsealed it made it harder for the pharmacy to show that the medicines had been stored in appropriate conditions. The packs were labelled with the information the person needed to take their medicines in the correct way. No patient information leaflets (PILs) were supplied, meaning that people could not easily access the information provided by the manufacturer about their medicines. There was a summary sheet in the pharmacy for each person receiving these packs showing any changes to their medicines and where the medicines were to be placed in the packs. There were no more empty multi-compartment compliance pack trays, meaning that unless some were received that week, patients would be left without medicines. The staff contacted head office, at the request of the inspector, and some trays were received by the end of the week.

Schedule 4 controlled drug prescriptions were not usually highlighted to staff who were to hand them out. Prescriptions for warfarin, lithium or methotrexate were not flagged by the staff when inputting data or when labelling or doing the final check and so the team members did not ask people about any recent blood tests or their current dose. So the pharmacy could not show that it was always monitoring the patients in accordance with good practice or the SOPs. The staff were not aware that they should routinely counsel people in the at-risk group who were receiving prescriptions for valproate about pregnancy prevention but there were no patients in the at-risk group using the pharmacy at the time of the inspection.

CDs were stored securely. The pharmacy got its medicines from licensed wholesalers, but it did not store them in a tidy way. There were many loose foils on the shelves, and other stuffed into boxes of medicines, which increased the likelihood of someone picking the wrong medicine off the shelves or mixing medicines up. For example, a foil of loperamide 2mg capsules was found on top of some letrozole 2.5mg tablets. Some of the pharmacy's medicines were not stored securely. Fridge temperatures were recorded daily and were within the recommended range. Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for its services.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for use with certain medicines, reducing the risk of cross-contamination. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not contaminate other tablets. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. The information on computer screens could not be seen by the public.

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.