

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, 468 High Street, KINGSWINFORD,
West Midlands, DY6 8AW

Pharmacy reference: 1038368

Type of pharmacy: Community

Date of inspection: 17/06/2019

Pharmacy context

This is a community pharmacy located on a busy main road, near to the centre of town. A local GP surgery is also close-by. The pharmacy mainly dispenses NHS prescriptions and it delivers medication to people who are housebound. It also sells a small range of over-the-counter medicines. The pharmacy provides other NHS services including Medicine Use Reviews (MURs) and the New Medicine Service (NMS). A substance misuse treatment services is also available.

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 does not always identify and manage risks appropriately. Team members have not received proper training on procedures. And the team does not effectively effectively record and learn from its mistakes.
		1.7	Standard not met	The pharmacy does not always keep people's private information as safe as it should, which may increase the risk that confidentiality could be breached.
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 not all met

Summary findings

The pharmacy does not always identify and manage risks appropriately. Team members are unfamiliar with the written procedures which define their responsibilities and help make sure they complete tasks safely. And they could do more to learn from their mistakes. The pharmacy keeps the records it needs to by law. But its information governance procedures are lacking, so it may not always protect people's private information as well as it could do.

Inspector's evidence

The company had a set of electronic standard operating procedures (SOPs) in place to cover pharmacy services. Team members present on the day were unable to access the procedures. They reported that they had not yet been provided with individual account details to enable access to the company intranet. The pharmacist said that she had previously read the procedures when working at another branch. Both apprentices confirmed that they had only read one SOP, which had been printed for them. The "EPS2 Dispensing Procedure" had been signed and dated in May 2019. One of the apprentices had been in post since January 2019. Following the inspection the superintendent pharmacist confirmed that team members had been provided with passwords when the company had taken ownership of the pharmacy, but that team members had likely forgotten this. The superintendent pharmacist confirmed that this had been rectified post inspection and that team members would work through the procedures.

Records of near misses were not maintained, although the pharmacist confirmed that she was aware that it was good practice to do so. The pharmacist said that any near misses were discussed at the time, and that action was taken to reduce the risk of mistakes happening again. An example provided was the separation of amlodipine and amitriptyline. The details of dispensing incidents were recorded through the pharmacy dispensing system. A record had been made for an incident at the end of May 2019. This had not been populated with any information. The pharmacist was unable to recall the details of the incident and said that failure to complete the record had been an oversight on her part. Other records of incidents were seen to be complete. However, in some instances, the reported actions which had been taken in response, were noted to not have been implemented in the pharmacy. Such as the separation of different strengths of propranolol and sertraline.

Pharmacy team members were observed to work within their roles during the inspection. One apprentice was unclear as to the activities which could and could not take place in the absence of a responsible pharmacist (RP), and said that completed prescriptions could be supplied. Training on RP regulations had not been provided. The team reported that the pharmacist did not usually leave the premises and no recent RP absences had been recorded.

The pharmacy had a complaint procedure in place. A notice which advertised the details of this was positioned near to the consultation room. The pharmacist said that concerns were resolved within the pharmacy where possible or they were directed to head office. The pharmacy also obtained feedback through an annual community pharmacy patient questionnaire (CPPQ).

Professional indemnity insurance arrangements were in place.

The correct RP notice was conspicuously displayed near to the medicine counter. The RP log was completed daily with registrant details. The log was also used to record the details of other team members who were present. Team members signed into the log and confirmed themselves as 'not responsible' on the system. There were two instances seen where an apprentice was ticked as being 'responsible', as well as the RP. This may cause ambiguity when reading the log.

Controlled Drugs (CD) registers were held in a paper format and running balances were maintained. Patient returned CD were recorded and destructions were signed and witnessed.

Private prescription and emergency supply records were generally in order. Specials procurement records available on the day did not provide an audit trail from source to supply, in line with requirements.

Pharmacy team members had not completed any information governance training. The pharmacist said that she had completed some training on confidentiality through the Centre for Pharmacy Postgraduate Education (CPPE). A designated bin was available to enable confidential waste to be segregated. However, during the inspection, a significant quantity of patient identifiable information was found in some general waste bags, which were secured and awaiting disposal. Information included repeat prescription request forms and excess dispensing labels. These were immediately removed from the bag by the pharmacist and placed in the appropriate confidential waste bin. The pharmacist said that team members had been informed of the correct procedure for the disposal of confidential waste, and that this would again be reinforced. Completed prescriptions were stored out of public view. Only the pharmacist was in possession of a valid NHS smartcard, which meant that other team members had to rely on others to access information from the NHS spine.

The pharmacist had completed level 2 safeguarding training through CPPE and discussed some of the types of concerns that may be identified. Safeguarding contact details were accessible to enable escalation. A chaperone policy was in place and the details were displayed in the consultation room.

Principle 2 - Staffing ✓ Standards met

Summary findings

There are enough team members to manage the current workload. Team members complete training for their roles and receive some feedback on their performance, so that they can make improvements.

Inspector's evidence

On the day of the inspection, the pharmacy team comprised of the regular pharmacist and two apprentice dispensers. The pharmacy employed an additional trainee who was not present. The team were able to adequately manage the workload. There were some outstanding electronic prescriptions to be dispensed from the end of the last week. These were managed repeats which were not due until later in the week. Leave was planned in advance and restrictions were in place to help to ensure that appropriate staffing levels were maintained. Nearby branches were approached for additional staffing support, if required. All team members employed by the pharmacy are trainees and so inexperienced. This may create added pressure, as they are not always familiar with all the tasks which require completion.

Several appropriate sales and referrals were observed during the inspection. Team members identified some of the questions that they would ask to help ensure that sales were appropriate. The pharmacist also discussed how she would manage a circumstance where it was felt a patient was frequently requesting medication.

Pharmacy team members were enrolled on training through two local colleges. An apprentice also reported that he had previously attended a company training event on a pregnancy related topic, and a local service provider recently attended the branch to provide information on topics such as emergency hormonal contraception (EHC) and alcohol dependency. A company director had also previously provided some on the job training to the apprentices, when working at the pharmacy. Reviews were held alongside apprentice course tutors to monitor development and give feedback on performance. A planned review for one apprentice had recently been cancelled. The apprentice had followed this up with the college and said she would continue to do so.

The team were happy to discuss issues amongst one another and stated that they were comfortable in contacting other members of management. The team were unaware as to whether the company had a whistleblowing policy in place to facilitate anonymous concerns. The pharmacist was aware that dependent on the nature of the concern, external bodies such as the General Pharmaceutical Council (GPhC) could be contacted.

There were targets in place for MURs and contact was made via telephone to check on service numbers. The pharmacist said she would not carry out a service unless it was appropriate and necessary for a patient.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a suitable environment for the delivery of healthcare services.

Inspector's evidence

The pharmacy's premises were suitably maintained. There was clear signage to the front, the retail area stocked a range of appropriate healthcare-based goods and there was a selection of health promotion literature. Pharmacy restricted medicines were secured from self-selection.

An enclosed consultation room was accessible from the retail area. The room was well maintained and had the necessary equipment and facilities to enable private and confidential discussions.

The dispensary had sufficient space for the current workload. A front area had two main work stations, to enable dispensing and checking to be clearly separated. A second area was fitted with additional work bench space and was utilised for managing medicine deliveries and for additional dispensing, when required. Numerous shelves were fitted to provide additional storage space. A there was a sink fitted for the preparation of medicines.

The pharmacy had an additional storeroom and WC facilities, were equipped with appropriate handwashing materials. Some of these areas needed cleaning.

Maintenance issues were escalated to head office and pharmacy team members carried out daily cleaning duties.

There was adequate lighting throughout the premises and the temperature was appropriate for the storage of medicines.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services which are generally accessible, and it manages them adequately. The pharmacy obtains medicines from reputable wholesalers. But pharmacy team members do not always make extra checks when supplying high-risk medicines. So, there is a chance people may not have access to all the information that they need to take their medicines safely.

Inspector's evidence

The pharmacy was located on a busy main road, near to the centre of the town. There was a single step up to the front entrance. A portable ramp facility was not available, which may mean that access is restricted for some individuals. The manual door was visible from the medicine counter and the pharmacist said assistance was provided with entry, if required. Additional adjustments were available to aid those with disabilities, such as the production of large print labels from the pharmacy computer system. A hearing loop device was available, but it was unclear as to whether this worked.

There were some service advertisements throughout the retail area and additional health promotion literature was displayed. The pharmacy opening hours were listed at the entrance and had been updated to reflect a recent change, where the pharmacy no longer opened on a Saturday. Internet access was available to support signposting.

Baskets were used for dispensing to keep prescriptions separate and reduce the risk of medicines being mixed up. Dispensed and checked boxes were signed as an audit trail for dispensing. Assembled prescriptions which were awaiting collection were stored in an organised manner. However, original prescription forms were not retained for reference at the point of handout, so, team members may not always have easy access to important information at the time of supply. And this also increased the likelihood that uncollected prescriptions could be claimed for in error.

Stickers were available to highlight prescriptions where additional counselling was required. Prescriptions for high-risk medicines such as warfarin and lithium were not routinely highlighted and records of monitoring parameters such as INR readings were not recorded. The pharmacist was aware of the risks of the use of valproate-based medicines in women who may become pregnant and discussed the counselling she would provide. But the pharmacy did not have access to the safety literature required as part of supplies. The inspector advised on how this could be obtained, and the pharmacist said that this would be followed-up post inspection.

Prescriptions for schedule 3 and 4 CDs which were not subject to safe custody requirements were not routinely highlighted, which may increase the risk that a supply could be made after the prescription has expired.

The pharmacy ordered repeat medicines for patients. The computer maintained a record of specific medicines which had been requested, but the team did not keep a record of repeat requests which had been sent to the GP surgery. This may mean that unreturned prescription requests may not be proactively identified. This could occasionally cause delays in supplies. And examples were seen during

the inspection where patients presented to collect their medicines, and it had not been identified that the local GP surgery had not issued a prescription. Delivery record sheets were in use. Entries appeared to be signed by the delivery driver, where a patient was not in at the time of delivery, medicines were returned to the pharmacy.

The pharmacy sourced medicines through reputable wholesalers and specials from a licensed manufacturer. Stock was organised in a reasonable manner. The team reported that date checks were carried out every other month, but no record of this was maintained. No out of date medicines were identified during random checks by the inspector. Out of date and returned medicines were stored in designated waste bins. Although hazardous waste guidelines were displayed, there was no access to a cytotoxic waste bin and, during the inspection, a box containing in excess of 30 betahistine tablets was found to have been disposed of in a general waste bag, which was secured and awaiting disposal. These were immediately removed and placed in the appropriate medicine waste bin but might mean that the team is not always able to show that medicines are disposed of appropriately.. The pharmacy did not currently have any systems in place to enable compliance with the European Falsified Medicine Directive (FMD).

The pharmacy fridge had a maximum/minimum thermometer. The temperature was checked and recorded each day and was within the appropriate temperature range during the inspection.

CDs were stored securely. Out of date and returned CDs were clearly segregated from stock. CD denaturing kits were available.

Alerts for the recall of faulty medicines and medical devices were received via email. It was reported that the system was checked daily. A class 2 (action within 48 hours) drug recall issued by the MHRA on 13th June 2019 was yet to be acknowledged. This was printed and actioned on the day.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to deliver its services safely.

Inspector's evidence

The team had access to paper-based reference materials and internet access supported additional research.

A range of glass crown-stamped and ISO approved glass measures were available for measuring liquids. Separate measures were marked for use with CDs. Counting triangles were available for loose tablets and a separate triangle was reserved for use with cytotoxic medicines.

Electrical equipment appeared to be in working order and some recent PAT test stickers were in place. Computer systems were password protected and screens were located out of public view. Cordless phones enabled conversations to take place in private.

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.