General Pharmaceutical Council

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: 11/02/2020

Pharmacy context

This quiet community pharmacy is 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 sells a limited range of over-the-counter (OTC) medicines. It also offers a home delivery service. Other NHS services available include Medicines Use Reviews (MURs) and a substance misuse treatment service.

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 identifies and manages risks adequately. It has written procedures to help make sure team members complete tasks safely and it keeps the records it needs to by law. Team members are clear about their roles. They keep people's private information secure and they understand how to raise concerns to protect vulnerable people.

Inspector's evidence

The pharmacy had a full set of standard operating procedures (SOPs) covering operational tasks and activities. The procedures had been reviewed within the last two years and defined the responsibilities of team members. The pharmacist, who was working his second day in the branch, was provided with electronic access to the procedures on the day. But he was already familiar with them from a previous role. Records confirming staff acknowledgment of the procedures were unavailable, but both dispensers, who had only been working in the branch for a short time, confirmed that they had read the procedures and the pharmacist said that he also planned to review the procedures with them. Through discussion and observation, team members demonstrated an understanding of their roles. They could accurately describe the activities which were permissible in the absence of a responsible pharmacist (RP). A displayed certificate of professional indemnity insurance had expired, but post inspection confirmation was provided that the policy had been renewed with no break in cover.

The pharmacy had recently been reliant on locum pharmacist cover, during this time the locum pharmacists had kept a paper record which contained some brief details of near misses which had occurred. Team members also indicated that verbal discussions about near misses had taken place at the time they were identified, but some under recording may mean that underlying themes and trends are not detected. The team were comfortable discussing near misses and said that they needed to be aware of mistakes so that they could learn from them. The pharmacist discussed how he would report a dispensing incident and said that onward reporting to the National Reporting and Learning System (NRLS) would also take place. As the team were all new to branch, they were unaware of any recent incidents.

The pharmacy had a complaint procedure and a notice in the retail area explained how concerns could be raised. The pharmacy also completed the NHS Community Pharmacy Patient Questionnaire (CPPQ) annually. A feedback poster from 2018 displayed positive results. The team were unaware of the results of a more recent questionnaire.

The correct RP notice was displayed by the medicine counter. The RP log was maintained. It recorded the details of the RP but it also included the other team members who were present at the pharmacy, which may at times cause some ambiguity. Recent private prescription and emergency supply records were recorded electronically, and a private prescription register was also available. Specials procurement records did not provide an audit trail from source to supply. This was discussed with the pharmacist, who agreed to follow this up with the team post-inspection. Controlled drugs (CD) registers kept a running balance and a recent balance check had been conducted for most CDs, but checks were

sometimes sporadic. A patient returns CD destruction register was available.

The pharmacy had an information governance procedure. A dispenser discussed how people's private information was kept safe. This included storing completed prescriptions out of public view and segregating confidential waste, which was then removed for suitable disposal by an external contractor. Only the pharmacist had a working NHS smartcard on the day. Other team members were in the process of arranging to obtain cards, so that they were not reliant on others to access the NHS spine.

The pharmacy had completed a safeguarding module through the Centre for Pharmacy Postgraduate Education (CPPE). Other team members had some awareness of safeguarding issues, and the pharmacist said that he planned to discuss this with them further. He outlined some of the types of concerns that might be identified and discussed an issue that he had raised in a previous role. The contact details of local safeguarding agencies were accessible to support escalation.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team can manage the current dispensing workload. Recent staffing changes have created some additional workplace pressure, but a stable workforce is now in place. Team members complete training for their roles and they get some feedback on their development.

Inspector's evidence

On the day of the inspection the regular pharmacist was working alongside two dispensers, who were both completing training. The pharmacist was new to the branch and both dispensers had also only been based at the branch for several days, replacing previous employees. In recent weeks staffing changes had created some difficulties. The new team had been brought in to create stability within the pharmacy and resolve some issues that had been identified, but the current skill mix did create some additional pressure, as both of the dispensers were inexperienced. The pharmacist discussed the plans that were in place for this and the team were receiving additional support from a qualified dispenser on an ad hoc basis, to allow staff to get up to date with certain tasks, such as date checking and the general organisation of paperwork. The team had some electronic prescription downloads to complete for the day, but there was no backlog in dispensing. Cover was usually available for planned leave to help maintain staffing levels.

Both team members were new to their roles, one was already enrolled on a dispensary assistants course provided by Buttercups and the other was due to be enrolled. The requirements for this to be done within three months of commencing employment were discussed. Time for the completion of training was allocated and when at a previous branch, one dispenser had received regular progress reviews with the pharmacy manager. The regular pharmacist said that he would now assume that role and would make sure that team members were progressing in the manner that they should be. A dispenser also discussed some previous training courses that he had intended. Most recently one related to alcohol awareness issues.

The team discussed the sale of medications in the pharmacy, including the questions that they would ask to help make sure sales were safe and appropriate. They demonstrated an awareness of the restrictions on the use of codeine-based medications and said that they would monitor for frequent purchases. Concerns were referred to the pharmacist in charge.

A dispenser said that concerns could be discussed with other dispensary colleagues and was also comfortable to approach the new pharmacist. The pharmacy owner was contactable, as was the pharmacy superintendent. But team members were not always sure about how concerns could be raised anonymously, which may restrict the ability for concerns to be raised in this manner. The need for this had not occurred to date. The pharmacist said some targets were in place for MURs. The patient medication record (PMR) system was used to identify people who may be suitable for services and the pharmacist said that he did not feel pressure relating to targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitably maintained for the provision of its services. It has a consultation room to enable it to provide members of the public with access to an area for private discussions.

Inspector's evidence

The pharmacy premises were in a suitable state of repair. Any maintenance concerns were escalated to the company's head office and daily housekeeping duties were completed by the pharmacy team. The pharmacist was in the process of arranging for the retail area to be fully cleaned during his first few days in the branch. On the day the patient facing areas were reasonably well maintained, but some staffing areas were still in need of cleaning. There was adequate lighting in the premises and the temperature was suitable for the storage of medicines.

The retail area stocked a small range of suitable goods for sale and pharmacy restricted medicines were secured from self-selection. There were two chairs available for use by people who were waiting for their medicines and no obstructions were on the floor. A selection of health promotion posters and other literature were displayed on a wall near to the chairs in the pharmacy. The pharmacist said that he would review the materials to make sure that they were all still suitable. Off the retail area was an enclosed consultation room, which was clearly signposted. The room was appropriately maintained and fitted with a desk and seating to facilitate private and confidential discussions.

The dispensary had adequate space for the provision of services. In the front area were two labelling terminals and separate work benches which were used to segregate dispensing and checking. Further work bench space was available in a rear section of the dispensary, where additional shelving was also installed for the storage of medicines. A small tearoom and WC facilities were also available.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are generally accessible and suitably managed, to help make sure people get their medicines safely and they receive all the information and advice they need. The pharmacy sources medicines appropriately and team members carry out some checks to make sure that they are fit for supply.

Inspector's evidence

The pharmacy was accessible via a step from the main street. A portable ramp facility was not available, which may restrict access to the premises for people with mobility issues. The manual door was visible from the medicine counter and team members assisted people, when required. The PMR system could generate large print labels to assist people with visual impairment, and the pharmacy had a hearing loop, but it was unclear whether this was in working order.

There was limited advertisement of pharmacy services. A poster promoted the availability of MURs and a leaflet explaining the prescription collection service was also available. A practice leaflet was not available on the day. The team had some access to information to support signposting. A dispenser discussed where a local needle exchange programme was available and said that he would phone ahead to check that services were available. He was also aware of the location of the local walk-in centre for referrals.

Prescriptions were dispensed using baskets to keep them separate and an audit trail for dispensing was maintained using dispensing labels. An example was seen where a prescription for methotrexate had been highlighted to ensure that suitable counselling and monitoring took place. The pharmacist said that he would usually try and identify other prescriptions for high-risk medicines and keep records of monitoring parameters where possible. He was unsure as to whether this had previously routinely been done. The pharmacist was aware of the risks of the use of valproate-based medicines in people who may become pregnant. The necessary safety literature could not be located on the day. The pharmacist was advised on how further copies could be obtained, if the materials were not found following a search of the dispensary. The pharmacy also identified prescriptions for fridge medications and CDs, but this did not extend to schedule 3 and 4 CDs, which were not subject to safe custody requirements. This may increase the risk that a supply could be made beyond the valid 28-day expiry date.

The pharmacy provided a prescription collection service. They had previously automatically requested repeat prescriptions for some people, but in recent weeks the electronic audit trail used to track this had not been correctly reconciled, which may lead to delays in unreturned prescriptions being identified. Moving forward the pharmacist discussed a system where patients contacted the pharmacy to request the medications which were required, to help make sure that requests were only placed when necessary and to help prevent the over ordering of medicines. The pharmacist discussed the delivery system and said that he had requested that signatures be obtained to confirm the delivery of medicines. Previous records could not be located to confirm whether this had previously taken place.

Stock medications were sourced through licensed wholesalers and specials from a licensed manufacturer. Stock medications were stored in the original packaging provided by the manufacturer and were organised. Some date checking records were available, but checks had not been completed since November 2019. The pharmacist said that as part of the ongoing cleaning schedule he would ensure that date checks were carried out. One expired medicine was identified from random checks of the pharmacy shelves. This was immediately removed and placed in a suitable medicines waste bin. Some expired gabapentin was identified in a medicines waste bin, this was segregated by the pharmacist for suitable destruction and the pharmacist agreed to review CD denaturing requirements with the team. Alerts for the recall of faulty medicines and medical devices were received via email. The system was checked daily and recent alerts had been marked as read on the system, but an up to date audit trail recording the action taken in response had not been maintained in recent weeks. The pharmacist agreed to review this moving forward. The pharmacy was not yet fully compliant with the requirements of the European Falsified Medicines Directive (FMD), implementation was being managed by the company's head office.

The pharmacy fridge was fitted with a maximum and minimum thermometer. It was within the recommended temperature range and records of temperatures were maintained. CDs were stored appropriately, and expired medicines were clearly marked and segregated. Random balance checks were found to be correct and the pharmacist agreed to obtain some CD denaturing kits. Prescriptions for substance misuse patients were dispensed on the morning of collection and secured in the CD cabinet until collected.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services and team members use equipment in a way that protects privacy.

Inspector's evidence

The pharmacy had several crown-stamped glass measures available and separate measures were marked for use with CDs. Counting triangles were clean and a separate triangle was reserved for use with cytotoxic medicines. The pharmacy team had access to a current paper edition of the British National Formulary (BNF). Internet access was also available to assist with further research.

Electrical equipment had been PAT tested in May 2019 and equipment appeared to be in working order. Pharmacy computer equipment was password protected and screens were located out of public view to protect privacy. Cordless phones enabled conversations to take place in private, if required.

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.