General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, Acklam Road, MIDDLESBROUGH, Cleveland, TS5 4EQ

Pharmacy reference: 1088684

Type of pharmacy: Community

Date of inspection: 19/09/2019

Pharmacy context

The pharmacy is an area near to the centre of Middlesbrough. The pharmacy is next door to an addiction centre. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy offers a prescription collection service from local GP surgeries. And it delivers medicines to people's homes. It supplies medicines in multi-compartmental compliance packs. This helps people remember to take their medicines. And it provides NHS services such as flu vaccinations, emergency hormonal contraception (EHC) and a substance misuse service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 team members record and report any errors made when dispensing. And it keeps the records it must by law. It advertises how people can provide feedback and raise concerns and listens to their feedback to make improvements for people accessing the pharmacy. It has processes available to its team members, to help them protect the welfare of vulnerable people. The pharmacy has processes and procedures to help the team manage the risks to services. These are passed their review date. So, this may mean that the pharmacy team members are not working to the most recent version.

Inspector's evidence

There was a small retail area to the front and a small dispensary. There was a separate entrance to the rear of the pharmacy where people could collect their medication, and where supervised consumption and needle exchange took place. The pharmacy had a set of standard operating procedures (SOPs) for the team to follow. These were due to be reviewed in January 2018. The newer members of the pharmacy team were in the process of reading and signing these. The pharmacy team used an error log to log errors that occurred during the dispensing process. The pharmacist on picking up an error, handed the prescription back to the dispenser responsible to correct. And to record on the error log. The pharmacist discussed near misses and as they occurred. The records looked at lacked details such as the contributory reasons why the error had occurred. And what changes had been made to prevent a similar error occurring. The action taken section when completed had generic actions such as “be careful”. The pharmacist manager explained that there had been an error when a member of the pharmacy team had selected an insulin pen when cartridges were required. The manager explained to the pharmacy team, the differences in the Novomix insulins stocked. The pharmacy team members explained that they discuss medicines that have similar packaging and separate these. No specific examples were provided. There had been a dispensing error recorded when a person had received 36ml of methadone when in fact 12ml for three days was required. The person subsequently received naloxone for the overdose. The accountable officer (AO) had been informed of the error. The manager advised that one of the contributory factors was that the incident happened late in the afternoon when the pharmacy was very busy.

The pharmacy team members said that they would refer any concerns to the manager. The team responded to people’s preferences, and when possible, stocked peoples preferred brands. There had been a complaint when a patient had been supplied with an out of date inhaler. The manager had escalated the complaint to the area manager who dealt with the complaint and apologised. The manger thought that the inhaler must have been short dated when it was supplied. So now inhaler stock was date checked when it was delivered. The pharmacy had appropriate professional indemnity insurance. A sample of the CD register entries checked met legal requirements. The pharmacy maintained the register with running balances. And these were audited monthly. Headers were completed in the CD register. The private prescription records looked at were complete. A register was maintained of CDs returned by patients for destruction and was complete and up to date. A sample of records for the receipt and supply of unlicensed products were complete. The pharmacy team members had not completed information governance training yet. The manager advised that he had spoken to the pharmacy team about the need to protect people’s information from unauthorised entry. The team were aware of the importance of, and the need to protect people's private information. The

Confidential waste was segregated. The team said that the waste was collected and destroyed off site. The RP had completed safeguarding training. And the pharmacy's team members said that they would refer any concerns to the manager. There had been no concerns raised to date.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services. Pharmacy team members engage in informal shared learning following mistakes during the dispensing process. And feel able to make suggestions for change to improve services.

Inspector's evidence

The pharmacy team, on the day consisted of the RP who was also the manager and three other members of the pharmacy team. One had recently been enrolled onto the initial assessment course for Buttercup training Level 2. No training had been completed so far. Another member of the pharmacy team had started with the company in August and was not yet registered on a registered training course. The manager explained that the third member of the pharmacy team was leaving the company in December. The manager said that sometimes they struggled because they were a new inexperienced team. And due to the nature of the business. Supervised methadone was labour intensive. Members of the team worked extra hours to cover each other's holidays. All three members of the team worked thirty hours. The area manager, who was a dispenser, covered when necessary.

The team were registered for Numark training and could access training electronically. Members of the pharmacy team had their own log in and password. And completed training at their own discretion. No examples of training completed were provided. The team did not receive appraisals. The manager said that it was a small team and he gave on the spot feedback when necessary. The team usually had informal discussions about the day ahead in the morning. Near misses were discussed as they occurred. But they did not record any details of these discussions. This meant that there was the potential for staff not on duty to miss some learning opportunities. Because the team members were new they relied on the manager and they found him very helpful and approachable. They had discussed the lack of space in the pharmacy. The manager had responded to this by getting a small dispensing station for the assembly of multi-compartmental patient packs. This was a helpful and provided a quiet place to assemble the packs. They had also discussed ways to make the workflow more efficient. The controlled drugs cabinets had been changed round to make access easier. And this was also helpful. The team were unsure if there was a whistle blowing policy. They said that they would approach the manager if they had a professional concern.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean and suitable to provide its services safely. The pharmacy’s team appropriately manages the available space. And it has a suitable consultation room for people to have private conversations. But the team sometimes forget to log out of the computer. So, this may mean that information is not always protected from unauthorised access.

Inspector's evidence

The pharmacy was small. But the pharmacy team made best use of the space available. The pharmacy premises were clean. The dispensary had separate areas for dispensing and checking prescriptions. There were two consultation rooms. But only one was in use as a consultation room the other was used as a stock room. The consultation room was suitable for private consultations and counselling. There was a desk, computer and chairs. Its location was well advertised. The consultation room was accessed by a door from the retail area. It was closed but unlocked. The computer screen was on with access to a dispensing error report which contained patient information. The manager said that he was unsure why the screen had not gone off after a period of inactivity. He said he would look into this. He thought it may have been that a member of the team had been using the computer just before we entered the consultation room. The layout of the premises was such that confidential information was not visible from the public areas. The pharmacy’s premises were appropriately safeguarded from unauthorised access. There was adequate heating and lighting throughout the premises. And running hot and cold water was available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The services are generally well managed. The pharmacy identifies people who take higher-risk medicines. And these people get the information they need to help take their medicines safely. The pharmacy gets its medicines from reputable suppliers. And it mostly stores and manages its medicines appropriately.

Inspector's evidence

There was a wide door to the front of the premises. And this made it easier for wheelchair users to access the pharmacy and its services. The pharmacy opening hours were displayed in the window. There were some leaflets on display for self-selection. Multi-compartmental compliance packs were supplied to people to help them to take their medicines on time. These were going to be prepared at another branch form next month due to the space restrictions in the pharmacy. The pharmacy offered a free delivery service to people in their own homes. The delivery driver got signatures from the person accepting the medicines. And these was a separate sheet for people to sign for CD deliveries. There was no patient returned or out of date CDs in the controlled drugs cabinet. There was a date checking procedure and the pharmacy was fully date checked every two months. There were records for this. The procedure was to highlight short-dated medicines. Random checks of the pharmacy shelves found that stock was in date and the procedure was being followed. Opened bottles of liquid medications were marked with the date of opening to ensure they were still safe to use when used for dispensing again. For example, Oramorph was marked as opened on 5 July 2019. The dispensers were observed using baskets to ensure prescriptions were prioritised and assembled medication remained organised. Computer generated labels included relevant warnings and were initialled by the pharmacist and dispenser which allowed an audit trail to be produced. There was an adequately sized retrieval area where dispensed medication for collection was stored. People collecting their prescriptions were routinely asked to confirm their details to ensure that medication was supplied to the correct patient safely.

The pharmacy team were aware of the Pregnancy Prevention Programme. And were aware that there was guidance that had to be provided to people who may become pregnant who received valproate. The cards and leaflets were in the consultation room. Which may mean that these were not easy to access when needed to supply to people taking valproate. The manager advised that he had completed an audit and there were no eligible patients. The manager said that he routinely has discussions with people taking high risk medicines such as warfarin. And he routinely put notes of these discussions on the patient's medication records. The records confirmed that this was happening. Out of date stock and patient returned medication were disposed of in pharmaceutical waste bags for destruction. These were stored securely and away from other medication. A sample of invoices showed that medicines and medical devices were obtained via licensed wholesalers such as AAH and Phoenix. Stock requiring refrigeration was stored at appropriate temperatures. And electronic records were maintained to ensure temperatures were within the appropriate ranges. The records showed that these were consistently recorded. The team were aware of the Falsified Medicines Directive (FMD). But were not aware of any action the company had taken to date to comply with the regulation. Recalls and MHRA alerts were received electronically. These were printed off only if the pharmacy had stock. These were actioned, the actions were noted, and then the alert was filed. But there was no audit trail to indicate

that all alerts were received and read.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe, and the pharmacy uses it appropriately to protect people's confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. Tweezers and gloves were available to assist in the dispensing of multi-compartmental compliance packs. There was a suitably sized fridge used to store medicines that needed refrigeration. Prescription medication waiting to be collected were stored in a way that prevented people's confidential information being seen by members of the public. Cordless phones assisted in undertaking confidential conversations. The pharmacy had a hand pump for pumping methadone.

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.