General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, 4 Strawberry Place, Morriston, SWANSEA, West Glamorgan, SA6 7AG

Pharmacy reference: 1092641

Type of pharmacy: Community

Date of inspection: 30/01/2024

Pharmacy context

This pharmacy is next door to a medical centre in Morriston. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a range of services including emergency hormonal contraception, smoking cessation and treatment for minor ailments. Substance misuse services are also available.

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 has written procedures to help make sure the team works safely. Its team members record some of their mistakes so they can learn from them. And they take some action to help stop mistakes from happening again. But they do not always record or review all their mistakes, so they may miss some opportunities to learn and improve. The pharmacy keeps the records it needs to by law. It keeps people's private information safe. And its team members understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had some systems in place to identify and manage risk, including the electronic recording of dispensing errors. Near misses were not usually recorded, but the dispensing assistants explained that pharmacists discussed near misses with them at the time of each occurrence, and that any emerging patterns or trends were discussed with the whole team. Some action had been taken to reduce risks that had been identified. For example, a highlight sticker had been used to alert staff to the risk of selection errors with the 'look-alike, sound-alike' drugs amitriptyline and amlodipine, and these two products had been distinctly separated on the dispensary shelves. A poster describing the process to follow in the event of needlestick injury was displayed in the consultation room.

The pharmacy had recently changed ownership and the team were in the process of reading and signing a new set of electronic standard operating procedures (SOPs) which underpinned the services provided. However, some of these appeared to be overdue for review, and some referred to procedures that were specific to England. This meant that some SOPs might not accurately reflect the activities taking place in the pharmacy. However, the pharmacy team were able to describe their roles and responsibilities and understood which activities could and could not take place in the absence of the responsible pharmacist.

Verbal feedback from people using the pharmacy was mostly positive. But some people were unhappy that the pharmacy was not always able to obtain the stock medicines they needed. The pharmacy team gave assurances that this situation was improving. A formal complaints procedure was in place, but this was not advertised.

A current certificate of professional indemnity insurance was available. All necessary records were kept and were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials, and controlled drug (CD) records. The RP register was also used to record details of the times at which all pharmacy team members started and finished work each day. And some entries had incorrectly recorded a non-pharmacist as being the RP for short periods of time, which was confusing. The pharmacy team said that this was an oversight and had occurred as they were not familiar with the new computer system.

Members of the pharmacy team had signed a confidentiality SOP. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. They explained that they would soon be receiving a shredder to allow them to dispose of confidential waste on the premises. Several large bags of confidential waste were being stored securely in the pharmacy toilet and the team were aware that they did not have the time or resources to shred

the contents of these during working hours. However, they explained that they planned to discuss the matter with a member of the management team to arrange for the waste to be removed and disposed of appropriately.

The pharmacist had undertaken formal safeguarding training. All other team members had read the safeguarding SOP. The team had access to guidance and local contact details via the internet. Information leaflets for people affected by dementia were on display in the retail area.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. Pharmacy team members understand their roles and responsibilities. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacy operated using locum pharmacists. Different pharmacists worked on Mondays, Tuesdays and Wednesdays and a regular pharmacist worked every Thursday, Friday and Saturday. The pharmacy team consisted of three full-time dispensing assistants (DAs) and one part-time trainee DA. The trainee DA worked on Saturdays under the supervision of a pharmacist or another trained member of staff. The staffing level appeared adequate for the services provided. However, the company were in the process of recruiting another dispensing assistant to help the team manage the workload. Members of the pharmacy team were observed to use appropriate questions when selling over-the-counter medicines and referred to the pharmacist on several occasions for further advice on how to deal with transactions.

There was no structured training programme in place. Informal training materials such as articles in trade magazines and information about new products from manufacturers were available and members of the pharmacy team said that much of their learning was via informal discussions with the pharmacist. There was no formal appraisal process. The lack of a structured training and development programme increased the risk that individuals might not keep up to date with current pharmacy practice and that any training needs might be missed.

The company did not set targets for the services provided. Pharmacy team members were seen working well together. They explained that they were able to make suggestions within the team and felt comfortable raising concerns with the pharmacist or a senior member of the management team. An electronic whistleblowing policy was available in the dispensary. It included details of organisations that could be contacted if team members wished to raise a concern outside the organisation.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and secure. It has enough space to allow safe working and its layout protects people’s privacy.

Inspector's evidence

The pharmacy was clean, tidy and well-organised. Some stock and dispensed prescriptions awaiting collection were being temporarily stored on the floor, but these did not pose a trip hazard. The sinks had hot and cold running water and soap and cleaning materials were available. A consultation room was available for private consultations and counselling, and this was advertised appropriately. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises the services it provides so that people know about them. But the pharmacy entrance is not suitable for wheelchairs. So, some people may not be able to access all of the pharmacy's services. If the pharmacy can't provide a service, it directs people to somewhere that can help. The pharmacy's working practices are safe and effective. It stores medicines appropriately and carries out some checks to help make sure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There were steps up to the pharmacy entrance which were not accessible to wheelchair users or other people with limited mobility. An external lift next to the steps had been decommissioned several years previously. The pharmacist explained that the team would go out to patients who were unable to access the pharmacy and help them where possible. Or they would signpost them to other nearby pharmacies or other healthcare providers, such as the adjacent surgery, for any services they could not provide. Some healthcare information was displayed in the retail area.

Most of the pharmacy's prescription business came from the adjacent medical centre. Dispensing staff used colour-coded baskets to help ensure that medicines did not get mixed up during dispensing and to distinguish between different people's prescriptions. Dispensing labels were initialled by the dispenser and accuracy checker to provide an audit trail. Controlled drugs requiring safe custody and fridge lines were dispensed in clear bags to allow staff members to check these items at all points of the dispensing process and reduce the risk of a patient receiving the wrong medicine. The clear bags were then put into paper bags at the point of supply to ensure that patient confidentiality was not compromised.

Stickers were attached to bags of dispensed medicines to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

Prescriptions for patients prescribed high-risk medicines such as warfarin, lithium and methotrexate were usually marked with stickers to identify the patient for counselling. A dispensing assistant said that the team asked people prescribed high risk medicines about relevant blood tests and dose changes but did not record these conversations. The pharmacy team were aware of the risks of valproate use during pregnancy. They were also aware of the requirement to supply valproate products in original packs wherever possible. A valproate patient information pack was available in the dispensary. The pharmacist knew of several patients prescribed valproate who met the risk criteria. He confirmed that they were counselled and provided with information at each time of dispensing.

The pharmacy supplied medicines to some people in multi-compartment compliance packs. The packs were usually labelled with descriptions of the medicines they contained so that individual medicines could be easily identified. However, some descriptions were missing, and patient information leaflets were not routinely supplied, so there was a risk that people might not always be able to make informed decisions about their own treatment. A list of patients and their delivery or collection

arrangements was displayed in the dispensary for reference.

There was a steady uptake of the common ailments service and the emergency supply of prescribed medicines service. The pharmacy provided a discharge medicines review service, but local hospitals did not always send electronic copies of discharge letters to the pharmacy through the Choose Pharmacy software platform. So, the pharmacy team was often reliant on patients bringing paper copies of their discharge letters to the pharmacy. This meant that uptake of the service was relatively low. The pharmacy offered a supervised consumption service but did not currently have any clients. It also provided a smoking cessation service (supply only) and an EHC service. Blood pressure and blood glucose measurement was provided on request at the pharmacist's professional discretion. The pharmacist was a qualified independent prescriber but said that he did not currently provide any prescribing services.

The pharmacy provided a prescription collection service from three local surgeries. It also offered a free prescription delivery service using agency drivers. Signatures were obtained for deliveries of controlled drugs. In the event of a missed delivery, the driver put a notification card through the door and brought the prescription back to the pharmacy.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were stored in a large, well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in a well-organised CD cabinet and obsolete CDs were segregated from usable stock. The pharmacy stored some P medicines in glass cabinets in the retail area, which were marked 'Please ask for assistance with these medicines'. The cabinets were not locked but were covered by CCTV that could be viewed from the dispensary. There was usually a member of staff at or near the medicines counter who could intervene if a member of the public attempted to self-select a medicine.

There was some evidence to show that regular expiry date checks were carried out, but the frequency and scope of these checks were not currently documented. This created a risk that out-of-date medicines might be overlooked. However, no out-of-date medicines were found present in the dispensary. Short-dated items were highlighted with stickers and the pharmacist said that he always included an expiry date check as part of his final accuracy check. Date-expired medicines were disposed of appropriately, as were waste sharps and patient returns. The pharmacy received drug alerts and recalls via email. The pharmacy team described how they would deal with a drug recall by contacting patients where necessary, quarantining affected stock, and returning it to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services. And it makes sure these are always safe and suitable for use.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Separate measures were used for methadone to prevent cross-contamination. Triangles were used to count loose tablets and a separate triangle was available for use with cytotoxics. The pharmacy had a range of up-to-date reference sources.

All equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. However, the pharmacy team were only able to use one computer terminal in the dispensary to scan prescriptions for dispensing. Two other terminals could be used for tasks such as reprinting labels or amending patient records, but it was clear that the pharmacy team would be able to manage the workload more efficiently if all three terminals were able to scan prescriptions. The team explained that this issue had been reported internally.

Equipment and facilities were used in a way that protected the privacy and dignity of patients and the public. For example, the pharmacy software system was protected with a password and the consultation room was used for private consultations and counselling. Computer screens were not visible to people using the pharmacy.

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.