General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, Westbury Hill Medical Centre, Westbury Hill, Westbury-On-Trym, BRISTOL, Avon, BS9 3AA

Pharmacy reference: 1093204

Type of pharmacy: Community

Date of inspection: 17/02/2020

Pharmacy context

This is a community pharmacy inter-connected with a medical centre in the northern suburbs of the city of Bristol. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells some over-the-counter medicines. The pharmacy also supplies medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines.

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 team do not identify and manage some risks to people's safety as a result of its working practices. Not all the team members have read all the company's written procedures and some of these are not being followed.
		1.2	Standard not met	The pharmacy team cannot provide assurance that they are recording and learning sufficiently from mistakes to prevent them from happening again.
		1.3	Standard not met	Some team members are not properly trained and so don't understand the procedures that they should be following.
		1.6	Standard not met	The pharmacy does not keep all the records it must by law.
		1.7	Standard not met	The team members do not protect people's private information.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough suitably qualified staff to manage its workload safely. And, they receive no additional support from the company when team members are on holiday or off sick.
		2.2	Standard not met	The team members do not do regular on-going learning and so their skills may not be up to date. And, those members in training are not allocated any dedicated time at work for their courses. This means that these may take much longer than normal to complete.
		2.5	Standard not met	The team members are comfortable about providing feedback to their immediate manager but some legitimate concerns, raised to higher management, are not acted on.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including	Standards not all met	4.2	Standard not met	Not all the pharmacy's services are managed effectively to make sure that

Principle	Principle finding	Exception standard reference	Notable practice	Why
medicines management				they are delivered safely. In particular, it has has poor procedures for any items that are owed to people. This means that some people may run out of their medicines.
		4.3	Standard not met	The pharmacy does not store or dispose of all its medicines safely.
		4.4	Standard not met	The team members cannot demonstrate that people only get medicines or devices that are safe.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy team do not identify and manage some risks to people's safety as a result of its working practices. Not all the team members have read all the company's written procedures and some of these are not being followed. The team members are not following the procedures for medicines owed to people which leads to confusion and may result in people running out of their medicines. The team cannot provide assurance that they are recording and learning sufficiently from mistakes to prevent them from happening again. Some team members are not properly trained and so don't understand the procedures that they should be following. The pharmacy does not keep all the records it must by law. The team members do not protect people's private information. Some members know how to protect vulnerable people but not the whole team.

Inspector's evidence

The pharmacy team did not identify and manage many risks and overall, governance procedures were poor. This was found to be the case at the last inspection visit on 26 July 2019. The pharmacy was deemed to come back into compliance in the follow-up visit on 2 October 2019. However, since then there had been some staff changes.

Dispensing errors and incidents were reported to be recorded but the staff did not know when the last error was. Few near misses were recorded, just two for the month of January 2020. A NVQ2 trainee dispenser said that the regular pharmacist was often required to self-check medicines. Those that were recorded, had insufficient information to allow any useful analysis. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded.

The dispensary was spacious and had recently undergone a re-fit. Over-the-counter medicines had been moved into the dispensary. The 'prescription only medicines' (POMs) had been re-located from drawers to open shelves. These contained no dividers which could increase the risk of picking errors. The shelves were untidy but the staff said that the re-organisation was not yet complete. A large box of patient-returned medicines was stored by the till. There was no barrier to prevent unauthorised access to these. A bottle containing mixed tablets with no labels was seen in the unlocked consultation room. The pharmacy was not using owing notes for items owed to patients. This is contrary to their written procedures. A problem was seen to arise as a result of this on the day of the visit (see further under principle 4). A person came in to collect the owed medicine but there was no record of this. An assembled multi-compartment compliance aid, waiting to be checked, was seen to have no completed dispensing audit trail.

Standard operating procedures (SOPs) were kept electronically. The pharmacy team included two new members of staff, employed in November 2019 and in January 2020. They were working on the medicine counter. They had not had a formal induction programme and had only read some of the pharmacy's procedures. They did not know what the pharmacy procedures for items owed to patients were. And, they had received no training on the appropriate procedures for dealing with returned medicines from patients, including those considered hazardous for waste purposes (see further under principle 4).

The staff were not clear about the complaints procedure. They all reported that they would refer these

to the pharmacist. However, on the day of the visit, the regular pharmacist was not working. The staff were unsure if they had completed a recent community pharmacy questionnaire (CPPQ). One trainee dispenser, employed since the current owners took over the business in January, said she had not given out any questionnaires to patients. The inspector checked the NHS England website. The last updated survey on the NHS England website was reported to have been done between January and March 2019, under the new owners. The dispenser seen said that the pharmacy had not received any feedback about this survey and she was unsure how it had been done since the pharmacy had not asked customers to fill in a questionnaire. The published feedback was about having more staff at busy times and more stock. This was the same as the previous survey reported to have been done between January and March 2018. The NHS website showed that both questionnaires had been updated on the same day, 14 October 2019.

Public liability and professional indemnity insurance, provided by Numark and valid until 6 January 2020, was in place. The responsible pharmacist log, specials records and fridge temperature records were in order. The staff said that they did routine date checking but the records for this could not be located on the day of the visit. The patient returned controlled drug (CD) register also could not be located. In addition, the CD cabinet contained large quantities of bagged unusable CDs for destruction. They were not clearly separated into returns and out-of-dates. Several bags were sealed and this did not provide confidence that the out-of-date CDs were being thoroughly checked when the routine CD balance was done. The staff said that private prescriptions were now recorded manually but the book for this could not be found. The electronic register showed many entries with no prescriber details. This was the case at the last visit on 26 July 2019.

An information governance procedure was in place but the newly employed staff had not read this. In addition, confidential information was seen in the unlocked consultation room and returned medicines were seen to have been placed in the bins for collection by the waste disposal company still with the patient labels attached. The pharmacy computers, which were not visible to the customers, were password protected. Confidential waste paper information used to be collected for appropriate disposal. However, the staff said that they had now been asked to shred it. They had only just purchased a shredder. There was a large bag of confidential waste and this was seen to have been put in the same bags as those used for waste medicines. No conversations could be overheard in the consultation room when the door was closed.

Not all the staff understood safeguarding issues and not all of them had read the company's procedures for the safeguarding of both children and vulnerable adults. The pharmacist seen, a locum, had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults.

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

Summary findings

The pharmacy does not have enough suitably qualified staff to manage its workload safely. And, they receive no additional support from the company when team members are on holiday or off sick. The team members do not do regular on-going learning and so their skills may not be up to date. And, those members in training are not allocated any dedicated time at work for their courses. This means that these may take much longer than normal to complete. The team members are comfortable about providing feedback to their immediate manager but some legitimate concerns, raised to higher management, are not acted on.

Inspector's evidence

The pharmacy was inter-connected with a medical centre in the northern suburbs of the city of Bristol. They mainly dispensed NHS prescriptions with many of these being repeats. But, due to the pharmacy's location, there were several acute 'walk-in' patients. Some domiciliary patients received their medicines in multi-compartment compliance aids. The assembly of compliance aids for several patients had been transferred to off-site hubs in Bristol and Birmingham. However, difficulties with this were reported and so many of the returned assembled compliance aids were still finally checked at the branch (see further under principle 4).

The current staffing profile was one pharmacist, one full-time NVQ2 trainee dispenser, mainly working on the medicine counter, one part-time NVQ2 trainee dispenser and two newly employed staff, November 2019 and January 2020, one part-time and one full-time, working on the counter. The part-time trainee dispenser was the main person working in the dispensary. At the time of the visit, she was doing the assembly of compliance aids that were due for delivery or collection the week of the visit. A couple were seen to be waiting for checking that were due the day following the visit. The part-time trainee dispenser had some flexibility to work extra hours to cover both planned and unplanned absences. But, the company was said not to provide any help, in either of these circumstances. The part-time trainee dispenser was responsible for the assembly compliance aids and said that as a result, the pharmacist often had to self-check other items. This increased the risk of errors. The two new members of staff had received no formal induction and they had not read some important procedures, such as information governance and safeguarding. The two staff members who had been employed for some time, trainee dispensers, said that they believed that the company had annual performance appraisals but they could not recall when the last one was.

The staffing profile was unusually top-heavy with counter staff and this led to pressure in the dispensary. There were no fully qualified dispensers. The part-time trainee dispenser had been enrolled on the course for a long time and still had not completed this. The trainee staff were not allocated any dedicated learning time for their courses. The staff were not enrolled on any regular on-going learning programmes. The part-time trainee dispenser said that she did some learning at home. The full-time trainee dispenser did none.

The staff said that they were supported by their manager (not seen). They had weekly staff meetings. The staff had raised some concerns about the proposal to re-locate the over-the-counter medicines to the dispensary but higher management had overridden these concerns. The staff were not aware of the company's whistle-blowing policy and procedures. The pharmacist seen, a locum, had not been set any

incentives or targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally looks professional and is suitable for the services it provides. It signposts its consultation room so it is clear to people that there is somewhere private to talk.

Inspector's evidence

The pharmacy generally presented a professional image. A very recent re-fit meant that some areas were not well organised. The dispensing benches were mainly uncluttered but several boxes of stock were stored on the floor. The staff said that this should be addressed shortly. The premises were clean and mainly well maintained.

The consultation room was spacious and well signposted. It contained a computer, a sink and two chairs. There was evidence of previous water damage to the ceiling tiles in here and this did not present a professional pharmacy image. A bottle of unlabelled mixed tablets as well as patient sensitive information was seen in here. The room was not locked (see under principle 1). Conversations in the consultation room could not be overheard. The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning and the temperature in the pharmacy was below 25 degrees Celsius. But, the heating was not working in the area where patients were waiting. There was good lighting throughout. All the items for sale were healthcare related but these were now located in the dispensary and so customers were not able to see what products were offered for sale.

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

Summary findings

Everyone can access the services the pharmacy offers. But, they are not all managed effectively to make sure that they are delivered safely. In particular, the pharmacy has poor procedures for any items that are owed to people. This means that some people may run out of their medicines. The pharmacy also does not store or dispose of all its medicines safely. And, the team members cannot demonstrate that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with an automatic opening front door to the inter-connected surgery. The staff could access an electronic translation application for use by non-English speakers. The pharmacy could print large labels for sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), the New Medicine Service (NMS) and the Community Pharmacy Consultation Service (CPCS). Not all the staff were aware of the services offered.

Some domiciliary patients received their medicines in compliance aids. Until recently, the pharmacy had prepared more of these but several had been transferred for off-site dispensing both in Bristol and in Birmingham. The dispenser mainly responsible for the assembly of these said that they had experienced difficulties with this. She said that the start dates were often incorrect and that some had the incorrect backing sheets. This meant that the pharmacy performed a final accuracy check of the compliance aids. This negated the easing of the workload by sending them for off-site assebly. And, as mentioned under principle 2, only one part-time trainee dispenser was responsible for the compliance aids. The recent re-fit to the pharmacy had also put the assembly of the compliance aids, done at the pharmacy, behind their normal schedule. The compliance aids still assembled at the pharmacy were done on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were individual poly-pockets where all the relevant information such as hospital discharge sheets and changes in dose were kept. These were referred to at the checking stage.

Owing slips were not being used for any items owed to patients. A patient came in to collect an owing 28 hyoscine tablets and a tube of piroxicam gel. She had not been given an owing slip but had called the pharmacy to say that her prescription was not complete. When the patient presented in the pharmacy, the prescription could not be located. On examination of the prescription medication record, it was seen that the prescription had been electronically transferred. The record also showed that the full amount had been issued thss demonstrating that an owing note had not been generated. There was a file containing prescriptions to be collected and some of these had labels of items still to be supplied. These could easily become detached. These procedures were not only disorganised but could potentially, mean that patients were left without vital medicines.

Another patient was seen to come in to collect sumatriptan nasal sprays, not available when he first came in on 12 February 2020. The medicines could not be found on the dispensary shelves and so the patient was told to come back the next day. Fortunately, he had not completely run out of the medicine.

There was an audit trail for all items ordered on behalf of patients by the pharmacy but not for all items dispensed by the pharmacy (see under principle 1). The pharmacist seen, a locum, routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. International normalised ratios were asked about. He also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were not packed in clear bags and the staff were not sure if the regular pharmacist checked these with the patient on hand-out. One member of the staff, the part-time trainee dispenser, was aware of the sodium valproate guidance relating to the pregnancy protection programme. She said that two 'at risk' patients had been identified and counselled and that guidance cards were included with each prescription for them.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, Lexon and Phoenix. Specials were obtained from Lexon Specials. Invoices for all these suppliers were available. CDs were not all stored tidily. There were several bags of unusable stock, mainly sealed but these were not clearly labelled. This gave little confidence that the out-of-date CDs were being checked as part of the routine CD balance check. In addition, the patient-returned CD records could not be found on the day of the visit. Moreover, the cabinet was so full that it was difficult to close. The staff were unable to say what they would do if they received any patient-returned CD medicines that day. Destruction kits were on the premises. Fridge lines were correctly stored with signed records. Date checking was said to be done but any records demonstrating this could not be found. Designated bins were available for medicine waste but a returned compliance aid, with the labels still attached, and hence, containing confidential information, was seen to have been placed in one bin. None of the staff could say if the waste provider accepted such waste containing confidential information. As mentioned under principle 1, there was also a large box of patient-returned medicines stored behind the counter where the till was situated. People could easily access this. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes. However, none of the staff were aware that all medicines containing the sex hormones were treated as hazardous for waste purposes.

There was said to be a procedure for dealing with concerns about medicines and medical devices. However, no one had checked for any alerts or concerns on the day of the visit. And, recent known alerts, such as for ranitidine tablets sent, on 3 February 2020, were not in the folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (100 and 250ml) and ISO stamped straight measures (10 -100ml). There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was shredded. But, a shredder had only just been purchased and there was a large quantity of confidential waste information to dispose of. It had previously been collected for suitable disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.