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: 02/09/2020

Pharmacy context

This is a community pharmacy in the north-western suburbs of the city of Bristol. It is interconnected with a medical centre. A wide variety of people visit the pharmacy. The pharmacy team members dispense prescriptions, sell over-the-counter medicines and give advice. They also supply a few medicines in multi-compartment compliance packs to help vulnerable people in their own homes to take their medicines.

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's working practices are generally safe and effective. And, it has put some physical measures in place to reduce the risk of transmission of coronavirus. The pharmacy is appropriately insured to protect people if things go wrong. It mainly keeps the required records. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy team members identified and managed most risks associated with providing its services. They had put some changes in place, as a result of the COVID-19 pandemic, to reduce the risk of transmission of coronavirus. The pharmacy was in the process of updating its standard operating procedures (SOPs) with changes relating to the pandemic. It had updated its business continuity plan to accommodate any potential issues relating to the current NHS 'test and trace' scheme. But the team members had not liaised with other close by pharmacies to ensure that there was no disruption in the supply of medicines to their patients if the pharmacy had to close. The superintendent had conducted risk assessments of the premises and occupational risk assessments of all the staff. The team members were asked about any potentially vulnerable people in their households and also about their mental health. The superintendent planned to review the risk assessments every three months. The pharmacy team members were aware that they needed to report any COVID-19 positive test results.

The pharmacy team members recorded near miss mistakes, that is, mistakes that were detected before they had left the premises. They documented learning points and some actions to prevent future recurrences, such as, where quetiapine 50mg had been given instead of 300mg. The item had been dispensed during the lunch period when the lights were turned off. The action to prevent a similar mistake again was not to dispense medicines in poor light. The pharmacy had had an error where sulphadiazine 50 mg had been given to a patient instead of sulphasalazine 50mg. The incorrect medicine had left the pharmacy. No specific actions had been put in place following this error.

The dispensary was large and generally organised. There were dedicated working areas, including a clear checking area. The dispensary team placed the assembled medicines and their accompanying prescriptions into baskets to reduce the risk of errors. The pharmacist only placed one basket at a time in the checking area which also reduced the risk of a mistake.

The staff understood their roles and responsibilities. A NVQ2 trainee dispenser knew that 'pharmacy only' medicines could not be sold to anyone if the pharmacist was not on the premises. A qualified NVQ2 dispenser knew that people should not use codeine-containing medicines for more than three days.

Not all the pharmacy team were clear about the pharmacy's complaints procedure. It had no leaflet available telling people how to complain. One staff member said that she would refer anyone wanting to make a complaint, to the pharmacist. The superintendent gave assurance that the staff would be trained on the complaints procedure and that the pharmacy would display a leaflet providing people with the details on how to make a complaint.

The pharmacy had current public liability and indemnity insurance. It kept most of the required up-to-date records: the responsible pharmacist (RP) log, controlled drug (CD) records, emergency supply records and specials records. The pharmacy kept electronic private prescription records. Several of these did not record the details of the prescriber. The pharmacy also had fridge temperature records, date checking records, patient-returned CD records and cleaning rotas.

The staff understood the importance of keeping people's private information safe. They stored all confidential information securely. The computers, which were not visible to the customers, were password protected. The correct NHS smartcards were seen in the appropriate computers. The pharmacy team members shredded all confidential wastepaper. The pharmacy was not currently offering any face-to-face services. But when these resumed, people could not be overheard or seen in the consultation room.

The pharmacy team understood safeguarding issues. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. The pharmacy had local telephone numbers to escalate any concerns relating to both children and adults. The pharmacist had heard of the national 'safe space' initiative for victims of domestic violence and said he would look into providing this service.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage their workload safely. The team members do their best to cover holidays and sickness. They are encouraged to keep their skills and knowledge up to date. The pharmacy team members are comfortable about providing feedback to the higher management.

Inspector's evidence

The pharmacy's current staffing profile was one pharmacist (the manager), two part-time NVQ2 qualified dispensers and one part-time NVQ2 trainee dispenser. At the beginning and at the end of the day there was usually just the pharmacist and one dispenser on duty. The pharmacy was often busy after 5pm and this level of staffing sometimes caused issues. The superintendent was actively trying to recruit apprentices to address this. But one team member would like to regularly work more hours. This had been declined by the pharmacy's head office. The part-time staff did their best to cover both planned and unplanned absences. But they could not cover all the hours.

The manager was very newly appointed (two weeks). He planned to regularly monitor the performance of the team members. And, to have a more formal annual appraisal with a six-monthly review where any team member could identify any learning needs. Also, he will introduce monthly staff meetings. The team members felt supported by the superintendent and said that he was approachable and caring.

The staff were encouraged with learning and development. They did regular on-line training but this not in work time. The trainee dispenser was not allocated dedicated learning time towards her course. The pharmacy's head office provided regular updates regarding coronavirus. The team members were supported to learn from errors. The pharmacist documented all learning on his continuing professional development (CPD) records. The team was not set any targets or incentives.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional and is suitable for the services it offers. It is clean, tidy and organised. The premises are thoroughly cleaned to reduce the likelihood of transmission of coronavirus.

Inspector's evidence

The retail area of the pharmacy was limited but there was a lot of underutilised space in front and to the side of this. The dispensary was spacious and organised. The dispensing benches were largely uncluttered and the floors were clear. The premises generally presented a professional image. But a plastic protective screen placed on the medicine counter, did not present a professional image and it did not afford the staff much protection from contracting coronavirus from people visiting the pharmacy (see further under principle 5). The premises were clean. As a result of COVID-19, the premises were cleaned three times a day. The hard surfaces were wiped over more frequently than this.

The consultation room was spacious. It was signposted but this could be more prominent. The room had some soiled ceiling tiles. People could not be seen or overheard in the consultation room. The pharmacy's computer screens were not visible to customers. The telephone was cordless and the staff took all sensitive calls out of earshot.

The temperature in the pharmacy was below 25 degrees Celsius and it was well lit.

Principle 4 - Services ✔ Standards met

Summary findings

Everyone can access the services the pharmacy offers. It generally manages its services effectively to make sure that they are delivered safely. The team members usually make sure that people have the information they need to use their medicines properly. They intervene if they are worried about anyone. The pharmacy gets its medicines from appropriate sources and stores them safely. The pharmacy makes sure that people only get medicines or devices that are safe.

Inspector's evidence

Everyone could access the pharmacy and the consultation room. The pharmacy team members could access an electronic translation application for any non-English speakers. They could print large labels for sight-impaired people.

The pharmacy was located in the north-western suburbs of the city of Bristol. It was interconnected with a surgery. Most of the pharmacy's prescriptions were electronically transferred from the adjacent surgery and most were for local residents. The surgery issued 12-month electronic repeat dispensing prescriptions. This sometimes caused problems when items were discontinued. The dispensary staff initialled the 'dispensed by' and 'checked by' boxes on the labels, so providing a clear audit trail of the dispensing process.

The pharmacy was currently not offering any face-to-face consultations. It was offering the New Medicine Service (NMS) and the Community Pharmacy Consultation Service (CPCS). But it had received few CPCS referrals. The newly appointed pharmacist was due to have face-to-face flu vaccination training in September 2020. He believed that the stock to provide this service had been ordered. The pharmacist planned to only offer the flu vaccination service by appointment. People will be asked to complete the pre-assessment form when they made an appointment. This will reduce the contact time between the person and the pharmacist in the consultation room and hence reduce the risk of transmission of coronavirus. Everyone who received the vaccine will wear a face covering and the pharmacist will wear full personal protective equipment (PPE): type 2R fluid resistant mask, face shield, apron and gloves. He will use alcohol gel or wash his hands before and after the vaccination. The appointment slots will be 30 minutes apart to allow the room to be thoroughly cleaned between appointments.

The pharmacy had no substance misuse clients who usually had their medicines supervised. It did have a few domiciliary people who had their medicines in multi-compartment compliance packs. The majority of compliance packs were assembled off-site. The adjacent surgery usually informed the pharmacy if there were any changes for these patients. But, the hub pharmacy did not mark the assembled medicines, indicating that the patient of their carer may need some counselling. The pharmacy team were aware of any changes or other issues for the compliance packs that they assembled themselves at the pharmacy, mainly in weekly packs. The pharmacist referred to these when doing the final accuracy check. The assembled compliance packs were stored tidily in a dedicated separate area.

The dispensary team highlighted any prescriptions containing potential drug interactions, changes in

dose or new drugs to the pharmacist. He targeted anyone he was concerned about for counselling. The pharmacist routinely counselled people prescribed high-risk drugs such as warfarin and lithium and also those prescribed antibiotics, oral steroids and complex doses. All the pharmacy team members were aware of the pregnancy protection programme regarding sodium valproate. The pharmacy currently had one 'at risk' patient who was prescribed sodium valproate. She received a guidance card with each dispensed prescription.

The pharmacy delivered several medicines to people. Because of the pandemic, the delivery driver did not currently ask people to sign for their medicines to indicate that they had received them safely. He knocked or rang the doorbell and left the medicines on the doorstep. The driver retreated and waited until the medicines had been taken safely inside. The driver annotated the delivery sheets accordingly.

The pharmacy got its medicines from Alliance Healthcare, AAH, Phoenix and Lexon. Invoices for all these suppliers were available. The pharmacy had no scanner to check for falsified medicines as required by the Falsified Medicines Directive (FMD). It stored its CDs tidily in accordance with the regulations and access to the cabinet was appropriate. The pharmacy had no out-of-date or patient-returned CDs. Appropriate CD destruction kits were on the premises. The pharmacy stored its fridge lines correctly and it had date checking procedures. The pharmacy team members were accepting patient-returned medicines. These were double bagged. The staff member who accepted the returned medicines wore gloves and washed their hands after disposing of the medicines into a dedicated waste bag. The team members placed any medicines, considered hazardous for waste purposes, into a separate dedicated waste bin.

The pharmacy had procedures for dealing with concerns about medicines and medical devices. It received drug alerts electronically. They were printed off and the stock was checked. The pharmacy had received a recent alert on 3 August 2020 about digoxin 250mcg tablets. It had none of the affected batches in stock and this was recorded.

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 it is clean. The pharmacy has taken some action to reduce the spread of coronavirus. But it could have more robust measures in place to reduce the risk of transmission of the disease.

Inspector's evidence

As a result of the pandemic, the pharmacy had erected a small, flimsy plastic screen across a section of the medicine counter. This was less than 0.5 meters long and there were large gaps which did not afford the staff much protection from contracting COVID-19. The superintendent gave assurances that more robust protection would be obtained. There was a large area in front and to the side of the medicine counter but no foot marks had been placed on the floor indicating where people should stand. In addition, there was sufficient space to create a one-way flow of people. This would make both people visiting the pharmacy and the pharmacy team members feel more secure. The staff were wearing Type 2R fluid resistant face masks. They cleaned the hard surfaces regularly throughout the day. And they used alcohol gel after each interaction with people.

The pharmacy used ISO stamped conical measures. There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. The pharmacy had up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. The staff could 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 the staff took any sensitive calls out of earshot. The pharmacy team members shredded all confidential waste information.

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.