

# Registered pharmacy inspection report

**Pharmacy Name:** Jhoots Pharmacy, Hickings Lane Medical Centre,  
120 Rycroft Street, Stapleford, NOTTINGHAM, Nottinghamshire,  
NG9 8PN

**Pharmacy reference:** 1101943

**Type of pharmacy:** Community

**Date of inspection:** 08/12/2021

## Pharmacy context

This pharmacy is co-located with a medical centre in the Nottinghamshire town of Stapleford. The pharmacy's main services include dispensing NHS prescriptions and selling over-the counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines. And it delivers some medicines to people's homes. The pharmacy was inspected during the COVID-19 pandemic.

## 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
<b>1. Governance</b>	Standards met	1.4	Good practice	The pharmacy actively encourages feedback from people using its services. And it responds well to the feedback provided by using it to help improve the standard of the services it provides.
<b>2. Staff</b>	Standards met	2.5	Good practice	The pharmacy encourages its team members to regularly feedback their ideas. And it is good at using this feedback to help inform the safety and quality of its services.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy identifies and manages the risks associated with its services appropriately. It keeps people's private information secure and it keeps the records it must by law. The pharmacy encourages feedback from members of the public. And it responds well to feedback by acting on people's comments to improve the way it delivers its services. Pharmacy team members understand how to recognise and respond to safeguarding concerns. And they engage in shared learning to help reduce risk following mistakes made during the dispensing process.

### Inspector's evidence

The pharmacy had addressed some risks associated with providing pharmacy services during the pandemic. Team members were confident when demonstrating steps taken to reduce risk. There was a plastic screen positioned at the medicine counter. This helped to maintain social distancing and reduced the risk of spreading the virus. Notices in window displays informed people of the need to wear a face covering when visiting. Pharmacy team members could not socially distance well in the dispensary due to the size of the work area. They had appropriate access to personal protective equipment (PPE) but not all team members wore these masks whilst working.

The pharmacy had standard operating procedures (SOPs) in place to support the safe running of the pharmacy. It stored most of these electronically and they covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The team had printed some key SOPs for immediate access. A sample of SOPs examined had been reviewed within the last two years by one of the company's senior pharmacists. But there was no indication that the Superintendent Pharmacist (SI) was involved in this review process. Training records associated with the SOPs were available. Most team members had read and signed the SOPs. One trainee team member who had worked at the pharmacy for around five months still needed to complete learning associated with all relevant SOPs. A discussion took place about the importance of scheduling time to complete this core learning. And the team member demonstrated competence in the tasks they undertook. For example, the team member was observed completing audit trails on medicine labels when dispensing. And provided a detailed overview of the tasks that could not take place in the absence of the RP.

The pharmacy had an electronic near-miss error and dispensing incident reporting record. And the pharmacy encouraged its team members to record their own mistakes within the record. Records presented for inspection showed consistent near miss and error reporting. The records included reflective comments on what had contributed to the mistake made. And the team recorded actions taken to help reduce the risk of a similar mistake occurring. The pharmacy team discussed their mistakes frequently. But the team did not record the details of these discussions. Team members demonstrated how they had acted to reduce risk following these conversations. For example, they clearly marked shelf edges to identify 'look-alike and sound-alike' (LASA) medicines. And the team stored these away from each other. Recent learning following a near miss had also involved team members making each other aware of a medicine that had been stored in an incorrect location due to similar packaging with another medicine. This had prompted the team to apply extra vigilance when unpacking the stock order.

The pharmacy had a complaints procedure in place. And it clearly advertised details of how members of

the public could provide feedback or raise a concern. The last inspection undertaken in May 2021 had identified a rise in concerns following a high turnover of staff. And it had also identified some concerns with the pharmacy's record keeping. The staffing situation had generally stabilised and team members were particularly good at taking feedback onboard to help support the safe delivery of pharmacy services. For example, the team had improved record keeping and audit trails for the medicine delivery service following a concern about missing medicine. The pharmacy had resolved the concern. And the improved audit trail now supported the team in answering queries related to who the medicine had been delivered to. Other concerns received around the time of the last inspection had prompted the team to explore how they could use the patient medication record (PMR) system to support the process of ordering repeat prescriptions on people's behalf. The team had gone on to use the system which provided a full audit trail of all medicines ordered through the pharmacy's managed repeat prescription service. This allowed team members to chase missing prescriptions and to ensure medicines were ready for people to collect when they attended. The team had also introduced a text messaging service to support people in attending the pharmacy only when their medicines were ready for collection.

The pharmacy advertised its privacy policy within the public area of the pharmacy. It stored personal identifiable records within staff only areas of the premises. The team held confidential waste in a box in the dispensary. And team members explained they were waiting for delivery of a new shredder. The amount of waste was manageable and the shredder was expected imminently. The pharmacy had procedures relating to safeguarding vulnerable adults and children. The RP had completed level two safeguarding training. Another team member had completed safeguarding learning in a previous role. And it was evident that all team members engaged in regular conversations related to their role in helping to protect vulnerable people. Pharmacy team members had access to contact details for local safeguarding teams. And they explained how they had recently reported a concern to the local surgery. The team had worked with the surgery to ensure the person affected received the right equipment to support the person in taking their medicines as directed. And the pharmacy team continued to apply extra vigilance to help ensure the measures taken were effective.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed the correct details of the RP on duty. Entries in the RP record complied with legal requirements. The pharmacy held its CD register electronically. It maintained running balances in the register and regular balance checks took place against physical stock. A random physical balance check conducted during the inspection complied with the running balance in the register. The pharmacy had a patient returned CD destruction register. And this was maintained to date. The pharmacy's Prescription Only Medicine (POM) register was available electronically. This was generally kept in order. But on occasion the record did not reflect the accurate date on which the prescription was written. This was due to the person labelling the prescription entering the date of dispensing rather than the date of prescribing within this section of the register. The pharmacy had introduced a folder to maintain records of any unlicensed medicines it dispensed. It had not dispensed any unlicensed medicines since the date of the last inspection.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has a small, dedicated team of people who work together well. Pharmacy team members demonstrate enthusiasm for their roles. And they are confident in sharing their thoughts and ideas to help drive up the standard of the services the pharmacy provides. Team members are supported through a regular appraisal process and they engage in conversations to help minimise risk. But they do not benefit from protected learning time. This means there is a risk of delay to their training due to other priorities within the pharmacy.

### Inspector's evidence

The pharmacy manager was the RP on duty, and worked alongside a qualified dispenser and a trainee dispenser. The trainee dispenser had successfully completed a placement at the pharmacy through the government's 'kickstart' scheme. And they were now in the process of enrolling on GPhC accredited training to support them in their role. The pharmacy also employed a part-time apprentice. But this team member was on unplanned leave on the day of inspection. Other team members had increased their hours to support the safe delivery of pharmacy services to cover this leave. A delivery driver attended the pharmacy regularly to support the medicine delivery service. Dispensing workload had increased since the last inspection. The team was up to date with current workload and was planning its managed workload well to help support them in meeting timescales through the busy Christmas period.

The RP held monthly informal one-to-ones with team members. And team members were supported through a structured learning and development review process. These reviews took place quarterly and the focus on learning to date had been associated with expanding services and improving the workspace. The pharmacy did not provide protected learning time for its team members. And this had contributed to the delay in all team members having the time to read SOPs. The dispenser was newly enrolled on an accuracy checking dispensary assistant course. And the trainee was due to start their accredited course in the New Year. A discussion took place about the importance of planning training time to support these training roles.

The RP confirmed that she felt well supported by both the team and senior managers. And targets related to services did not affect her professional judgement. The pharmacy's area manager visited regularly to provide support to the team. And morale within the team was good. In addition to regular conversations related to risk management and workload, the team had introduced a communication book. This helped team members to handover and prioritise tasks to ensure workload was up to date. The team used the book effectively by marking off tasks once completed. The pharmacy had a whistle blowing policy. And team members were keen to share their ideas and feedback to help drive improvement. They had worked together to implement a range of tools to support monitoring the frequency of tasks such as cleaning and date checking. And had recently introduced a prescription collection diary. This diary provided an audit trail of the prescription requests people made over the telephone to the pharmacy.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises are clean and secure. They provide a suitable space for the delivery of healthcare services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

### Inspector's evidence

The pharmacy was appropriately clean and secure. It consisted of a small public area, a consultation room, a dispensary, and staff facilities. The public area was clear of clutter and provided enough space for people to wait for their medicine or for a consultation. A low level gate divided the medicine counter from the public area, and provided access through to the dispensary. The carpet in the dispensary was worn in places but was not posing a health and safety hazard. A team member discussed the efforts made to clear the pharmacy of clutter since the last inspection. And this was seen to be effective as all areas of the pharmacy, including the private consultation room were organised. The team had enough space for completing dispensing activity with separate areas allocated for labelling, assembling and accuracy checking medicines.

Lighting was bright and ventilation was appropriate. Antibacterial soap and paper towels were available at designated hand washing sinks, and antibacterial hand gel was readily available for team members and members of the public to use. The pharmacy's consultation room was accessible to people. And the team had started promoting use of the room as its services had expanded. For example, the room was now used to complete appointments for flu vaccinations and the pharmacy hypertension case finding service.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy promotes its services well. And it makes them accessible to people. The pharmacy obtains its medicines from reputable sources. And it generally stores these medicines safely and securely. The pharmacy team uses audit trails effectively to help manage the pharmacy's dispensing and medicine delivery service. And the team provides some information when people collect their medicines. But it does not always provide additional information to people taking higher risk medicines or when supplying medicines in compliance packs.

### Inspector's evidence

The pharmacy was accessed through a push/pull door leading from the medical centre carpark. There was a range of health promotion posters displayed in the pharmacy window focussing on what people needed to do if they had symptoms of COVID-19, and promoting local community health and wellbeing services. The posters also advised people about current access arrangements into the pharmacy, including the need to wear a face covering. Pharmacy team members were aware of how to signpost people to another pharmacy or healthcare provider if they were unable to provide a service.

The pharmacy had reviewed its services since the last inspection. And it had begun to offer a flu vaccination service and the NHS hypertension case finding service to people. The RP had access to procedures and protocols to support these services and had completed the necessary training requirements to provide each service. The RP reflected on positive patient outcomes from the hypertension case finding service. And the pharmacy worked well with the neighbouring medical centre to ensure urgent referrals were dealt with as a medical emergency. This helped to ensure that people received the appropriate medical care and medicine to help manage previously undiagnosed hypertension. The pharmacy was preparing to expand its services further in the New Year by offering a smoking cessation service and a minor ailments consultation service. Planning and learning related to these services was underway.

The public area of the pharmacy was small, providing seating for people waiting for prescriptions or a service. The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. The RP was observed providing verbal counselling to people when handing out bags of assembled medicines. And she highlighted prescription forms to prompt these conversations with people. The pharmacy did not currently dispense valproate containing medicines to people requiring a pregnancy prevention plan. But the RP demonstrated full understanding of the requirements of the valproate pregnancy prevention programme. And explained the checks and counselling required as part of the dispensing process. The pharmacy had valproate patient cards and guidance booklets available to issue to people. A discussion about the management of higher risk medicines such as warfarin and methotrexate identified that the pharmacy did not always recognise these as medicines requiring additional counselling. This meant that the pharmacy did not always seek assurance that people taking these medicines attended for regular monitoring checks to support their care. The discussion signposted the team to resources and learning to support the continual care of people taking these medicines.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and informed workload priority. The pharmacy team kept original

prescriptions for medicines owing to people. It used the prescription throughout the dispensing process when the medicine was later supplied. Audit trails to support the prescription ordering and medicine delivery service were effectively maintained. People were not required to sign for receipt of their medicines through the delivery due to the ongoing pandemic.

The pharmacy provided medicines in multi-compartment compliance packs to some people. The team used the PMR system to record details of people's medicine regimens to support dispensing. And changes to medicine regimens were clearly recorded on the system. Assembled packs contained backing sheets with dispensing audit trails and accurate descriptions of the medicines inside each compliance pack. But the pharmacy did not routinely provide patient information leaflets for the medicines inside the compliance packs. This meant that people may not have all the information required to support them in taking their medicines. A discussion took place about the requirement to provide these leaflets.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner, and generally within their original packaging, on shelves throughout the dispensary. A small number of medicines were stored in labelled amber bottles. But the labels did not always contain full details of the medicines inside. For example, batch number, expiry date and assembly date. The amber bottles were brought to the attention of team members and a discussion followed about the safe storage of medicines. The pharmacy team followed a date checking matrix and completed regular checks of medicines to ensure they remained fit to supply. The team annotated details of opening dates on bottles of liquid medicines. This helped to identify if the medicine remained safe and fit to supply.

The pharmacy held CDs in a secure cabinet. Medicines storage inside the cabinet was orderly. The pharmacy's fridge was clean and was a suitable size for the amount of medicines held. The pharmacy maintained an electronic fridge temperature record which showed it was operating within the accepted temperature range of two and eight degrees Celsius. The pharmacy had appropriate medical waste bags available. It stored these in a suitable space, away from stock medicines. The pharmacy received medicine alerts through email and there was an appropriate process in place for checking these alerts against stock held by the pharmacy. The team reported these checks to their head office for monitoring purposes.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It monitors this equipment to ensure it remains safe to use. And pharmacy team members act with care by using the equipment in a way which protects people's confidentiality.

### Inspector's evidence

The pharmacy had up-to-date written and electronic reference resources available including the British National Formulary (BNF) and BNF for children. Pharmacy team members could access the internet and intranet to help resolve queries and to obtain up-to-date information. Computers were password protected, and positioned so information on computer monitors was not visible from the public area. The pharmacy stored bags of assembled medicines in a protected area. This meant details on bag labels were not seen from the public area of the pharmacy. Members of the pharmacy team used cordless telephone handsets. This meant they could move out of earshot of the public area if the phone call required privacy.

The pharmacy had a range of clean equipment available to support the delivery of its services. Equipment included counting apparatus for tablets and capsules, and crown stamped measuring cylinders for measuring liquid medicines. Separate equipment was available for measuring and counting higher risk medicines to reduce any risk of cross contamination. And the pharmacy had single-use consumables for the substance misuse and compliance pack services. The pharmacy's blood pressure monitor was on the list of monitors validated for use by the British and Irish Hypertension Society. The team completed a health and safety monthly checklist and this involved routinely checking the pharmacy's equipment and facilities.

### 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.