General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, Brierley Hill Health & Social Care Ctre, Off Little Cottage Street, BRIERLEY HILL, West Midlands, DY5 1RG

Pharmacy reference: 1102644

Type of pharmacy: Community

Date of inspection: 20/01/2020

Pharmacy context

This is a community pharmacy within a busy health and social care centre in Brierley Hill, West Midlands. The pharmacy is open extended hours over seven days. People using the pharmacy are from the local area and the pharmacy acts as a 'hub' and dispenses medicines in multi-compartment compliance packs for collection from other pharmacies. The pharmacy dispenses NHS prescriptions and provides some other NHS funded services such as Medicines Use Reviews (MURs) and the New Medicine Service (NMS).

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 risks associated with the hub and spoke model for dispensing compliance packs are not sufficiently identified and managed. The written procedures do not cover all aspects of the hub and spoke arrangement or outline who is accountable at each stage of the process. This is made more complicated due to the company structure.
		1.5	Standard not met	The pharmacy has not provided evidence of their current pharmacy professional indemnity insurance policy.
		1.6	Standard not met	Responsible pharmacist and emergency supply records are not maintained in accordance with legal requirements.
		1.7	Standard not met	Sensitive confidential information is passed between separate legal entities without the patient's consent.
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 not all met**

Summary findings

The pharmacy does not always identify and manage risks well. The team have written instructions to help make sure it works safely. But team members do not always follow them. This may increase the likelihood of things going wrong, or mean they miss learning opportunities. The pharmacy does not always obtain people's consent to share their information when dispensing compliance packs for other Jhoots pharmacies. Pharmacy records are not kept in accordance with the legal requirements.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. The SOPs were stored on the company intranet. Roles and responsibilities of staff were highlighted within the SOPs. Some new starters had joined pharmacy team in December 2019 and were still working through the SOPs. They had started with the 'MDS SOP' as this was the main activity carried out at the pharmacy. The previous superintendent (SI) had listed on the action plan submitted after the last GPhC inspection that a review of the MDS SOP was going to be completed, however, it was unclear whether the SOP had been reviewed and it did not appear to have been updated.

The written procedures available for the hub and spoke supply model did not address the concerns that had been identified at the previous inspection and these concerns were still ongoing. There were no additional SOPs or procedures available that formalised the hub and spoke model. Processes such as, the prescription ordering process, procedure for missing items or changes, continuity plan, error reporting, complaints, and accountabilities were not formalised. There had been an instance where a spoke branch had received part-completed compliance packs and a copy of the relevant prescription and the spoke branch was asked to add the missing items to the packs locally. This was not covered by the SOPs and raised questions about the legality of this as the spoke branch was a separate legal entity. And it was unclear who was accountable for the packs as there were different teams and pharmacists involved in the assembly process. On the day of the inspection there were 20 compliance packs that were due to be dispensed and supplied to a spoke branch on that day. The necessary stock had not been received and was due in that afternoon. It was unlikely that the spoke branch would receive the completed packs on that day, due to the time it would take to assemble and accuracy check the packs and the location of the spoke branch.

The pharmacy was in the process of transferring some of the compliance pack dispensing to other Jhoots pharmacies. The pharmacist said she would only accept new compliance packs if the company's 'MDS transfer checklist', and patient consent form had been provided by the originating pharmacy. The team explained that when they supplied a copy of the 'backing sheet' and a copy of the previous prescription when they transferred dispensing back to the other pharmacies. This process was not the process explained in the SOP and meant the patients had not necessarily been informed of this or consented to it. Jhoots pharmacies are owned by one of four separate legal entities, so patient information was sometimes being passed to a separate company. This also creates additional considerations when supplying part-dispensed packs back to a branch that is a separate legal entity. The responsible pharmacist (RP) did not believe that the pharmacy held a MHRA specials licence that allowed them to supply a separate legal entity with pre-packed medicines so they should only be supplying completed prescriptions for onward supply from a collection point.

The RP explained that they used an online near miss log and the dispenser involved was responsible for correcting their own error to ensure they learnt from the mistake. The RP explained that each near miss was discussed at the time to see if there were any reasons for the near miss, and it was used as a learning opportunity. The near miss log was reviewed for patterns and trends at the end of the month and discussed with the team to identify any learning opportunities. The near miss log could not be accessed during the inspection as the password had been changed.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A dispenser answered hypothetical questions related to responsible pharmacist (RP) absence correctly.

The complaints, comments and feedback process was explained in the SOPs. People could give feedback to the pharmacy team in several different ways; verbal, written and the annual NHS CPPQ survey. The branch team tried to resolve issues as they occurred and would refer to a company director or the superintendent if they could not resolve the complaint.

The pharmacy team did not have details of the current professional indemnity insurance arrangements and, at the time of writing this report, the SI's office had not responded to the request to provide details of the policy.

The responsible pharmacist (RP) notice was clearly displayed. At the start of the inspection it did not display the correct pharmacist's details, but this was promptly rectified. The RP log did not comply with legal requirements as the electronic report listed all members of staff that were present as being signed in as RP. This created multiple RP's at the same time, some of which were non-pharmacists and could cause confusion in the event of a query. The RP log was used to record staff attendance which is what created the issue.
The entries in the controlled drug (CD) registers were in order. A random balance check matched the balance recorded in the register. The patient returned CD register was used. A balance check for methadone was done weekly and the manufacturer's overage added into the running balance. A sample of private prescriptions were seen to comply with requirements. The emergency supply function on the electronic record was used to record when prescriptions for compliance packs were dispensed before they had been received from the spoke branch, so they were not actually emergency supplies. The prescription was supplied before the compliance pack was accuracy checked and supplied. This made it difficult to see the true emergency supply record. The RP explained that specials records were maintained with an audit trail from source to supply, however, they were sent to head office for storage, so they were not available for inspection. MUR consent forms were seen to be signed by the person receiving the service.

Confidential waste was stored separately to normal waste and was shredded. No confidential information could be seen from the customer area. The pharmacy staff had NHS Smartcards. Various information governance (IG) policies were in the SOPs. As the pharmacy did not have a copy of the consent form that was used for transferring compliance packs, it was unclear whether people were aware that their information was being passed to a different company.

Pharmacy staff answered hypothetical safeguarding questions correctly. Staff gave examples of what would be a safeguarding concern and local safeguarding contacts were available. The RP had completed Centre for Pharmacy Postgraduate Training (CPPE) on safeguarding and would contact the superintendent or head office for advice before making a referral.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services. Pharmacy team members complete the training they need to do their jobs. But they do not have formal training plans or protected time to complete ongoing training, so they may not always keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy team comprised of three regular pharmacists, three dispensing assistants, seven pharmacy apprentices and a medicine counter assistant. Six of the apprentices had started working at the pharmacy since the last inspection to replace apprentices that had finished their training and no longer worked at the pharmacy. So, some team members were relatively inexperienced. The team explained that some of the administration tasks associated with the compliance packs, such as placing prescription orders with the surgeries and chasing missing prescriptions, had become the responsibility of the other branches due to the time it was taking.

Holidays were booked in advance and to ensure there was enough cover available. The team co-ordinated their holiday and checked with the RP before submitting the request to head office. The pharmacists checked the rotas in advance and asked staff to change their shifts or work overtime to manage any gaps in the schedule.

The pharmacy apprentices completed training in accordance with the plan provided by the college they were enrolled at. The apprentices had reviews and observations from their college tutors and other members of staff had performance reviews with the branch manager. The pharmacy team worked well together during the inspection and were observed helping each other and moving onto the healthcare counter when there was a queue. Pharmacy staff had regular discussions in the dispensary to communicate messages and updates. The pharmacy staff said that they could discuss any ideas, concerns or suggestions with the pharmacists. Staff said they would speak to the pharmacists or college tutors if they had any concerns and the contacts details for head office were available if required. One of the company directors, who was a pharmacist, had been working at the pharmacy and had been making changes to the operational processes and pharmacy layout. The RP was observed making herself available to discuss queries with people and giving advice when she handed out prescriptions. Targets were in place for services; the RP explained that she would use her professional judgment and only offer services such as MURs when she felt that they were appropriate for the person.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services currently provided. It has a private consultation room, so members of the public can have confidential conversations and maintain their privacy.

Inspector's evidence

The pharmacy was smart in appearance and appeared to be generally well maintained. Any maintenance issues were reported to head office but were not always rectified promptly. For example, the automatic front door had broken so the external door was locked. This meant that people had to enter through the health centre entrance and this door was not automatic. The dispensary was an adequate size for the services provided; an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the worktops. There was a large shop area and all of the shelving was empty. The team explained that the owner was changing the stock layout and had returned the stock to head office, several members of the public asked the staff whether the pharmacy was closing due to the lack of stock.

There was a private soundproof consultation room which was used throughout the inspection. The consultation room was signposted and professional in appearance. Access was controlled as the door was behind a barrier. There were two additional rooms that could be accessed from the shop floor and were not in use.

The pharmacy was generally clean and tidy with no slip or trip hazards evident. The pharmacy was cleaned by pharmacy staff. The sink in the dispensary and staff area had hot and cold running water, hand towels and hand soap were available.

The pharmacy had air conditioning and the temperature in the dispensary felt comfortable during the inspection. Lighting was adequate for the services provided. Prepared medicines were held securely within the dispensary and pharmacy medicines were stored behind the medicines counter.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy opens early and stays open later than usual, so its services are readily accessible. It generally sources, manages and supplies medicines safely. But the pharmacy does not always label compliance packs properly or provide people with medicine leaflets. This means that people might not have easy access to all the information they need to take their medicines.

Inspector's evidence

The pharmacy was situated within a medical centre. It had an automatic door and step-free access from the street and a second entrance from the medical centre. The automatic front doors were not working at the time of inspection. A home delivery service was available for people that could not access the pharmacy. The pharmacy opened for longer hours than many other pharmacies which included late nights, Saturday and Sunday.

The pharmacy staff used local knowledge and the internet to refer people to other providers for services the pharmacy did not offer. The pharmacy did not have a practice leaflet containing information such as the complaints procedure, how the pharmacy stores confidential information or details of the services available. So people might not be aware of these processes or what services are offered.

A dispensing audit trail was seen to be in place for prescriptions through the practice of staff signing their initials on the dispensed and checked by boxes provided on medicine labels. There were some instances where neither the dispensed by or checked by boxes had been completed on completed prescriptions awaiting collection, so it was unclear whether they had been accuracy checked. Dispensing baskets were used to keep medication separate. Different coloured baskets were used to prioritise the workload.

Multi-compartment compliance packs were dispensed at the pharmacy and delivered to other Jhoots pharmacies for onward supply. A company director had developed a schedule for this, so the other pharmacies received a monthly delivery of compliance packs. This schedule was in the process of being updated as there had been various changes. Prescription requests were generated two weeks before they were due to be delivered and they were sent to the spoke pharmacy to take to the surgeries. The pharmacy informed the spoke pharmacy by email if they had not received prescriptions for the items requested by a cut-off point. If this happened, the spoke branch was then required to chase the missing prescriptions and dispense the compliance pack themselves. The notes section of the patient medication record (PMR) was used to record any notes about changes to medication. Patient information leaflets were not routinely supplied with packs. This is a legal requirement and without the leaflets, patients and carers may not have all the information they need to use the medicines safely.

Stickers were attached to prescription bags to assist counselling and hand-out messages for example, eligibility for a service, specific counselling or fridge item. Additional counselling materials were available to support valproate counselling.

Date checking records could not be located during the inspection, but the team said that date checking had been recently carried out. Medicines were obtained from a range of licenced wholesalers. Medicines were stored in an organised manner on the dispensary shelves and a stock order was

generated once the prescriptions had been labelled to reduce stock holding. Medicines were stored in their original packaging. Split liquid medicines with limited stability once opened were marked with a date of opening. SOPs had been updated to reflect the Falsified Medicines Directive (FMD) but the team members were unaware if any other changes that had taken place and they were not scanning barcodes. Patient returned medicines were stored separately from stock medicines in designated bins.

The CD cabinets were secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. The CD keys were in the possession of the RP and secured safely overnight. There was a fridge in place to hold stock medicines and assembled medicines. The medicines in the fridge were stored in an organised manner. Fridge temperature records were kept and records showed that the pharmacy fridges were working within the required temperature range of 2°C and 8°Celsius. Substance misuse prescriptions were dispensed in advance and this reduced work load pressure and the risk of dispensing incorrect doses when the person came to collect the prescription. Assembled substance misuse prescriptions were stored in the controlled drug (CD) cabinet. Dispensing bottles that had been used for supervised consumption of methadone were being re-used for the same person for several days before being discarded, which increased the risk of contamination.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely.

Inspector's evidence

The pharmacy had a range of up-to-date reference sources, including the BNF and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Separate measures were available for preparation of methadone. Counting triangles were available. Electrical testing had last occurred in May 2019. Screens were not visible to the public as members of the public were excluded from the dispensary. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.