General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, St. Chads Health Centre, Dimbles Lane, LICHFIELD, Staffordshire, WS13 7HT

Pharmacy reference: 1103584

Type of pharmacy: Community

Date of inspection: 30/07/2024

Pharmacy context

This community pharmacy is located inside St Chads Health Centre, Lichfield. Its main activity is dispensing NHS prescriptions which are mainly for people who are registered within the health centre. It also provides some additional NHS services such as Pharmacy First, New Medicines Service and emergency contraception. Some people are supplied their medicines in multi-compartment compliance packs to help take them correctly.

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 largely identifies and manages the risks associated with its services. Written procedures are available to help its team members work safely and effectively. But they have not read all of the procedures relevant to their role which may make it harder to demonstrate that they fully understand them. Members of the team do not always make a record of when things go wrong so they miss out on opportunities to learn and make changes to reduce the risk of errors. The pharmacy largely keeps accurate records that are needed by law. Team members generally understand how to keep private information safe, and they take appropriate action to safeguard people that are vulnerable.

Inspector's evidence

A set of electronic standard operating procedures (SOPs) were available, and each team member had individual log in credentials to access them. A record of when the procedures had been read and accepted was maintained but the two trainee dispensing assistants admitted they had not read all the procedures relevant to their role. This meant they may find it difficult to demonstrate they understand the processes that underpin the services that are being provided. Team members provided an assurance that they would read the SOPs as a matter of urgency. Roles and responsibilities were defined in the written procedures, so it was clear which team member was accountable for each part of the process. And team members were able to correctly explain the activities that could and could not take place if the responsible pharmacist (RP) took a short leave of absence.

Dispensing labels has been signed by members of the team to help identify who was involved in the assembly of each prescription medicine. This also helped the RP to highlight mistakes that had identified during the accuracy check known as near misses. Team members were required to identify their mistake and rectify it to aid their learning. But records of these mistakes were not made regularly, and the RP admitted that some may not have been recorded. Three nears misses had been recorded since January 2024 but information to explain which medicines were involved had been omitted. And the actions taken to reduce the risk of similar mistakes reoccurring were vague. This meant team members were not able to reflect on mistakes and take the opportunity to learn from them. The RP explained that they were focussing their efforts on reducing the amount of medicine stock on the shelves so that they can have better separation of the medicines to reduce the risk of picking errors. There were no recent dispensing errors, but the RP explained that they would record the error on the patient medication record (PMR) system which could then be viewed by head office and the superintendent pharmacist.

A complaints procedure was available and team members explained that they tried to resolve complaints informally and referred to head office when needed. A poster explaining how to raise a complaint was displayed in the dispensary near to the window hatch where people were being served. But due to the location, people may not always be able to see the information being displayed and therefore might not know the correct way to raise a complaint or provide feedback. The pharmacy had current professional indemnity insurance and a certificate to show this was available.

Records had largely been maintained in line with legal requirements. An electronic private prescription register was seen but the details of the prescriber were often missing or incorrect. So, it may make it difficult for team members to respond to a query. Controlled drug (CD) registers, RP records and

unlicensed medicines records were maintained as required. CD balance checks were completed frequently and the running balance of two CDs were checked against the physical stock and found to be correct. Patient returned CDs were recorded in a book and signed when destroyed.

Written procedures about information governance (IG) were available and team members generally took appropriate steps to protect people's information. They separated confidential waste and shredded it. And patient identifiable information was not stored in view of people using the pharmacy. However, team members were seen using smartcards that belonged to a colleague who worked at another branch to access the NHS system in order to receive electronic prescriptions. And another team member's smartcard was being used but they had not yet started working for the day. This could affect the integrity of the system's audit trails. The RP promptly stored the smartcards securely and used his own to access the NHS system.

A safeguarding policy was not available, but team members were able to explain the steps they would take to help protect vulnerable people. They had supported someone who presented to the pharmacy and required help. Team members were observed helping help the person and identifying what the issue was. They worked effectively with staff members from the health centre to make sure the vulnerable person, and their child, was kept safe and calm. The RP had completed safeguarding training and was aware of how to access the details of the local safeguarding leads.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to effectively provide its services. And it provides support to members of the team who are on training courses. Members of the team feel comfortable to raise concerns and provide feedback.

Inspector's evidence

The pharmacy team consisted of one regular locum pharmacist, one qualified dispensing assistant who was on maternity leave and two trainee dispensing assistants, one of whom was enrolled on to an apprenticeship programme. The other had not been enrolled on to a training course which meant they may not have the appropriate skills and knowledge for the role they were undertaking. The pharmacy operations manager provided confirmation that the team member had subsequently been enrolled on to a suitable course with a recognised provider. One of the trainee dispensing assistants felt well supported with their learning and development and they were provided with adequate learning time to complete their training. Head office provided support to cover any absences to help make sure a consistent service level was achieved. The pharmacy team members were seen working well together and they supported each other to manage the workload effectively.

The pharmacy did not complete annual appraisals with its team members so opportunities to discuss performance and further development may be missed. Members of the team felt comfortable raising concerns or providing feedback to the RP and head office. As the pharmacy team was small, meetings took place daily to discuss workload and changes to processes. Team members explained the questions they would ask when selling pharmacy medicines. And they identified medicines that are liable to misuse. In such cases, they would refer to the pharmacist if they felt the sale was inappropriate or if repeated requests were made.

Principle 3 - Premises ✔ Standards met

Summary findings

The environment is suitable for the provision of pharmacy services. The pharmacy premises are small, but its team members use the space effectively to safely manage the workload undertaken. A consultation room is available for people to have a private conversation with a member of the team.

Inspector's evidence

The pharmacy was clean, tidy and well-lit which made it suitable to supply medicines in an effective manner. There was no retail area as the pharmacy was situated at the entrance of the health centre. And the dispensary was small and narrow. But the team used the space effectively and there was enough clear workspace for medicines to be assembled safely. A small hatch was placed at the front of the pharmacy where people were served and handed their medicines. A clean sink was available and suitable for preparing medicines that required mixing before being supplied to people.

The pharmacy had a clean and tidy consultation room which was suitable for people to have a private conversation with members of the team if needed. The room was clearly signposted, so people were aware that one was available, and it was locked when it wasn't in use. The pharmacy had climate control available to help maintain a comfortable working temperature. The pharmacy was secured when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are easy for people to access. Its working practices are effective and generally safe. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So they might not always be able to check that medicines are still suitable, or give people advice about taking them. The pharmacy sources and stores medicines appropriately and carries out some checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

Access to the pharmacy was level via a large entrance into the health centre. There was wheelchair access to the consultation room. Various posters provided information about the services offered, and information was also available on the pharmacy's website. The opening hours were displayed near the window hatch where people were served. A delivery services was advertised but due to the recent departure of the delivery driver, the pharmacy was not offering the service and it was encouraging people to collect their medicines in the interim.

The pharmacy team initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to provide an audit trail. They used baskets to separate individual people's prescriptions to avoid items being mixed up. Dispensed medicines awaiting collection were kept on a shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Team members were seen to confirm the patient's name and address when medicines were handed out. However, prescriptions for schedule 3 and 4 CDs were not routinely highlighted, so team members may not always check that the prescription is still within the legal 28-day limit before they are supplied. The risk of this was discussed and the RP agreed to write the date of expiry on the prescriptions going forwards.

Prescriptions for higher-risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted, so there was a risk that counselling opportunities could be missed. This might also result in a lack of care continuity. Pharmacy team members were aware of the risks of using valproate containing medicines during pregnancy. They were also aware of the requirement to supply valproate products in original packs. The RP confirmed that anyone prescribed valproate who met the risk criteria were counselled and provided with educational information at each time of dispensing.

Some people received their medicines in multi-compartment compliance packs to help them take their medicines correctly. The packs were made at another pharmacy within the same organisation, and they were responsible for ordering the prescriptions and assembling the packs. The packs were then delivered back to the pharmacy for people to collect them. A few assembled packs were checked but the description of the medicines that had been dispensed into the packs were missing, so people may find it more difficult to identify them. And patient information leaflets had not been enclosed so the most up to date information may not be available to people. The risks of this were discussed with the RP and superintendent pharmacist (SI) who provided an assurance they would address it.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were kept in a well-organised fridge. Maximum and minimum temperatures for the fridge were usually recorded daily, although there were occasional gaps in the records. This might make it difficult for the pharmacy to be assured that these medicines are safe and fit for purpose. Recorded

temperatures were consistently within the required range. And the fridge temperature was seen to be in range during the inspection. CDs were stored in one small CD cabinet. Obsolete CDs were kept separately from usable stock to help reduce the risk of them being used.

There was some evidence to show that regular expiry date checks were carried out although a record of these checks were not documented. This created a risk that out-of-date medicines might be overlooked. One pack of medicine was found to be expired which was promptly removed from the shelf for disposal. Date-expired and patient returned medicines were disposed of appropriately. The pharmacy received email safety alerts and recalls for medicines and medical devices. The pharmacy team were able to describe how they would deal with a medicine recall but a record of this was not maintained which may make it harder to demonstrate the actions that had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains the equipment appropriately and keeps it securely.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting triangles. Separate measures and counting equipment for use with higher-risk medicines was available to reduce the risk of cross contamination. Members of the team had access to electronic resources such as the British National Formulary (BNF) and the electronic medicines compendium. This meant the pharmacy team could refer to the most recent information on medicines.

Electrical equipment looked to be in good working order. Two computer terminals were available for team members to use, and the screens were positioned in a way so that any confidential information could not be seen by people waiting in the pharmacy. Access to people's electronic data on the pharmacy's computers was password protected. An otoscope and blood pressure meter were available for the services provided. Calibration of these equipment was completed by head office.

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.