

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, 1 Robin Hood Walk, NEWARK-ON-TRENT, Nottinghamshire, NG24 1XH

Pharmacy reference: 1109566

Type of pharmacy: Community

Date of inspection: 03/01/2020

Pharmacy context

The pharmacy is in a medical centre close to the centre of a market town in Nottinghamshire. It sells over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers advice on the management of minor illnesses and long-term conditions. It acts as a collection point for people requiring their medicines to be supplied in multi-compartment compliance packs, designed to help people to take their medicines. And it provides a limited delivery service. This service is provided to people who are physically unable to collect their medicines from the pharmacy.

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 has not implemented standard operating procedures to support its team members in managing the risks with some aspects of its multi-compartment compliance pack service. And there is evidence that things have gone wrong with this service.
2. Staff	Standards not all met	2.2	Standard not met	Not all pharmacy team members are working towards completing a GPhC accredited training programme to support them in achieving the knowledge and skills required for their role. This means there is an increased risk of something going wrong due to limiting the skill development of trainee team members.
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 generally identifies and manages the risks associated with its services. But the pharmacy has not implemented written procedures to support its team members in managing the risks with some aspects of its multi-compartment compliance pack service. And there is evidence that things have gone wrong with this service. The pharmacy keeps people's private information secure. And it responds appropriately to feedback it receives about its services. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they have the skills and knowledge required to protect the safety and wellbeing of vulnerable people. The pharmacy generally keeps all records it must by law.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) in place. SOPs relating to responsible pharmacist (RP) requirements, controlled drug (CD) management and dispensary processes had last been reviewed in February 2019 by a member of the senior management team. Roles and responsibilities of the pharmacy team were set out within SOPs. Training records confirmed that most members of the team had completed training associated with SOPs relevant to their role. But a training record for the apprentice was not available. The apprentice discussed her role. And was knowledgeable about the tasks which could not take place if the responsible pharmacist (RP) took absence from the premises.

Since the last inspection in May 2019, the pharmacy had transferred workload associated with supplying medicines in multi-compartment compliance packs to a different pharmacy. It now acted as a collection point for this service. And some deliveries of the assembled packs took place from the pharmacy. The pharmacy did order prescriptions for people on the service. And the dispenser confirmed the prescriptions were sent directly from surgeries to the dispensing pharmacy through the Electronic Prescription Service. There was a SOP in place for transferring workload associated with this service along with a 'transfer checklist'. But both the RP and dispenser explained they had not seen this documentation before. The dispenser explained the transfer had been managed by a member of the pharmacy's senior management team. But she was aware that pharmacy team members had asked all people transferring to sign consent for changing their nominated pharmacy during the transfer process. This was particularly important as the dispensing pharmacy was owned by a different legal entity. Pharmacy team members discussed some concerns with the service. For example, packs being received and only part-assembled due to stock not being available at the dispensing pharmacy. In these cases, the pharmacy received a note and a copy of the prescription informing team members what was missing from the pack. The pack was then completed locally, checked and resealed. But there was no written SOP for this process to support staff in identifying and managing the risks associated with this practice. Pharmacy team members also explained there were occasions when packs were not received on time. And this meant they had to assemble a pack at short notice. The GPhC was aware of one occasion where this had led to a delay in a person receiving their medication due to a medicine being out of stock because of a manufacturing issue.

The dispensary was organised. Workflow was efficient. Pharmacy team members used separate areas of the dispensary for labelling, assembly and accuracy checking. The RP acted to manage high-risk

activities such as dispensing controlled drugs (CDs). For example, assembly of substance misuse medicines took place against the prescription in advance of people attending the pharmacy. This helped to reduce workload pressure. The pharmacy stored assembled doses in a secure CD cabinet. Pharmacy team members were observed informing the RP of a person attending to collect a CD. And the RP was observed checking details on the prescription with the assembled medicine prior to supplying it.

The pharmacy had a near-miss error reporting record. And reporting took place regularly. The RP completed the record and provided verbal feedback to the member of staff who had made the mistake. This member of staff then corrected their own mistake. Some entries contained further information such as learning points following a near-miss. But there was no regular formalised review of the record. The dispenser demonstrated recent actions taken to help reduce risk when dispensing medicines. For example, the pharmacy team had created 'look-alike and sound alike' (LASA) warning labels. And they had attached these to dispensary shelves to help prompt extra care during the dispensing process.

The pharmacy had a dispensing incident reporting process in place. The RP provided access to incident reports. And these were seen to be clearly recorded with follow-up action and learning applied following these types of mistakes. For example, pharmacy team members had reviewed their bagging process following an incorrect name and address label being attached to a bag of assembled medicines.

The pharmacy had a complaints procedure in place. But details of how people could report a concern or provide feedback about the pharmacy was not advertised. A member of the team explained how the pharmacy would manage feedback and seek to resolve it locally. She explained how details of the pharmacy's head office would be provided if a person wished to escalate a concern further. Pharmacy team members explained that feedback had increased in recent months. And this was said to be due to a reduction in staffing levels and a temporary gap in the pharmacy offering a free delivery service. The pharmacy was currently recruiting for two additional team members. And the delivery service was being provided by a national courier to people who could not physically collect their medication.

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 record was maintained electronically and was also used as a sign-in register by all pharmacy team members to record their working hours. The RP role was clearly identified within the record. A sample of the CD register found that it generally met legal requirements. Some entries were missing the address of the wholesaler when a CD was received. The pharmacy maintained running balances in the register. But it did not complete regular physical balance checks of its stock against the register. The last balance check of solid dose formulations was recorded on 22 July 2019. Methadone balances were checked more regularly. A discussion took place about the risks associated with irregular balance checks. And the RP acknowledged the advantages of completing balance checks regularly. A physical balance check of MXL 120mg modified release capsules complied with the balance in the register. The pharmacy did not have a CD destruction register for patient returned medicines. And a box of patient returned morphine ampoules were found within a CD cabinet. The RP confirmed that he had made several requests for a register with the pharmacy's senior management team. And he acted immediately to introduce a temporary written record of the returns held.

The pharmacy held the Prescription Only Medicine (POM) register electronically. Records for private prescriptions occasionally contained inaccurate prescriber details and prescribing dates. This was due to the pharmacy's computer system defaulting to the date of dispensing and regular prescriber if not manually changed at the point of labelling. The pharmacy recorded emergency supplies electronically. And included the nature of the emergency when making a supply at the request of a patient. It held

specials records in accordance with the requirements of the Medicine & Healthcare products Regulatory Agency (MHRA).

The team held records containing personal identifiable information in staff only areas of the pharmacy. It had completed learning related to the General Data Protection Regulation (GDPR). And the pharmacy had submitted its latest NHS Data Security and Protection (DSP) toolkit as required. The pharmacy transferred confidential waste to designated holding bags. Bags were sealed by team members and collected for secure destruction periodically.

The pharmacy had procedures relating to safeguarding vulnerable adults and children. The team had access to contact details for local safeguarding teams. A self-help group guide for Nottinghamshire was available and used by the team to signpost people to organisations offering support to individuals and families. The RP had completed level two training on the subject. And he explained how he would manage a concern. The dispenser had completed safeguarding training in a previous role.

Principle 2 - Staffing Standards not all met

Summary findings

Not all pharmacy team members are undergoing training appropriate for their role, in accordance with GPhC minimum training requirements. This means there is an increased risk of something going wrong due to restricting the skill development of trainees. Pharmacy team members engage in informal shared learning following mistakes during the dispensing process. And they know how to raise concerns about the pharmacy or its services if they need to. But the pharmacy doesn't always make changes in a timely manner, following feedback from staff.

Inspector's evidence

The pharmacy had been inspected in May 2019. And this inspection had found an unmet standard relating to staff training. Following the inspection in May 2019, the pharmacy had completed an improvement action plan. And it had provided evidence of staff enrolment on an accredited dispensary course. One team member who had been enrolled on the course had since left the pharmacy. And the other team member, did not believe the enrolment process had been finalised following the last inspection. The RP explained a decision had been made to allow this team member to concentrate on her customer service course rather than formal pharmacy training. A discussion took place about the need to meet the GPhC's minimum training requirements for pharmacy support staff.

Pharmacy services were being provided by a regular pharmacist, a qualified dispenser and an apprentice. The pharmacy had two vacancies and were in the process of recruiting two additional apprentices to these vacancies. Pharmacy team members were highly committed to their roles. And had been working hard to provide cover in recent months following two members of the team leaving. Item numbers during this time had reduced. Part of this reduction in workload was due to the multi-compartment compliance pack service moving to another pharmacy. The pharmacy team explained that support in the event of unplanned absence was likely to come from another of the company's pharmacies located approximately 20 miles away. The RP explained he had bought a family member into work with him to help support the cover of the Christmas Day rota. He explained the person providing support was a medical professional and had previously worked in a pharmacy environment. The support had been provided to supervise people visiting the pharmacy and to answer the telephone. And the RP explained he had discussed the one-off arrangement with the pharmacy's owner. A courier was providing the prescription delivery service. And the dispenser was observed providing a thorough handover of the pharmacy's requirements for the service to the courier prior to the courier leaving the pharmacy. The courier was also observed providing feedback about the deliveries and providing evidence of delivery when returning to the pharmacy.

Pharmacy team members did complete some continual learning associated with their roles. For example, healthy living training. Some of this learning was completing in team members own time due to the pharmacy only having limited access to the internet. Pharmacy team members did receive an appraisal and explained they had been well supported by their manager, who was on long-term leave. The RP was the acting manager and had worked at the pharmacy for approximately two months. He explained there were some targets associated with the delivery of services such as flu vaccination and Medicines Use Reviews (MURs). And discussed how he met these targets. He explained he liked the opportunity to speak to people about their medication during MURs.

The pharmacy team communicated mainly through informal discussions. It did not document these discussions. But there was evidence of the team acting to reduce risk following mistakes. The pharmacy had a whistleblowing policy. And pharmacy team members were aware of how they could raise a concern or provide feedback if required. Pharmacy team members spoken to confirmed they would feel confident to raise a professional or safety concern and escalate it if necessary. And a team member provided an example of how she had been able to speak to the owner directly about an issue. But the pharmacy's senior management team did not always act on feedback in a timely manner. For example, several maintenance issues were outstanding.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and secure. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room. The pharmacy's workspace is safe. But the pharmacy's owners do not always respond to maintenance requests in a timely manner.

Inspector's evidence

The pharmacy was modern and secure. Pharmacy team members reported maintenance issues to their head office. But these issues were not always fixed in a timely manner. For example, the light in the staff toilet had not been working for over six months. The RP had brought it an emergency lamp due to the issue to avoid any health and safety concerns. But pharmacy team members had reported the issue several times. The premises were clean and tidy. They were air conditioned. And lighting throughout the rest of the premises was bright. Antibacterial soap and paper towels were available at designated hand washing sinks.

A door leading off the public area provided access to a stock room. This held paperwork and dispensary sundries. Another door provided access to staff facilities and a sluice room. The dispensary was a sufficient size for providing the pharmacy's services. Work benches were free from clutter. And there were no slip or trip hazards evident.

The consultation room was a good size and it was clearly signposted. It was professional in appearance and allowed for confidential conversations to take place. A screened off area to the side of the dispensary provided private space for people accessing the supervised consumption service.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy advertises its services and makes them accessible to people. The pharmacy's routine services are delivered safely and effectively. People visiting the pharmacy receive appropriate advice and information to help them take their medicine safely. The pharmacy obtains its medicines from reputable sources. And it has suitable systems in place to ensure it keeps these medicines safe and secure.

Inspector's evidence

The pharmacy was accessed through a door at street level or from the ground-floor foyer of the adjoining medical centre. A wheelchair accessible stair-lift was in place alongside a couple of steps which led up from the medical centre entrance. Designated seating was available for people waiting for a prescription or service. Opening times and details of the pharmacy's services were advertised. It had a range of health information leaflets available to people. But a practice leaflet designed to provide further information to people about the pharmacy was not available. Health promotion displays in both the public area and pharmacy window were bright and engaging. 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 public area of the pharmacy was a good size. The pharmacy stored pharmacy (P) medicines behind the medicine counter. This appropriately protected them from self-selection. It had some processes in place to identify people on high-risk medicines. The dispenser was knowledgeable about the requirements of the valproate Pregnancy Prevention Programme (PPP). Warning cards and monitoring cards relating to high-risk medicines were available. The RP explained how people on medicines which required additional monitoring were spoken to verbally. These verbal checks included warfarin and methotrexate. But the pharmacy did not record any details of these checks on people's medication records. It had completed a safety audit relating to amiodarone in autumn 2019.

The RP had complete training ahead of providing the annual flu vaccination service. And records associated with the service were maintained. A legally valid patient group direction (PGD) was available for the administration of flu vaccinations.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and informed workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. The prescription was used throughout the dispensing process when the medicine was later supplied. An audit trail was in place for the prescription collection and delivery service. People were asked to sign for receipt of their medication through the delivery service.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. The team were aware of the Falsified Medicines Directive (FMD). But the RP explained he had not received any further information about how the pharmacy intended to comply with FMD requirements since the legislation had first come into law in February 2019. Pharmacy team members were aware of changes

to medicine packaging for example, checking tamper proof seals. The pharmacy received drug alerts by email. The team checked these and maintained details of alerts for reference purposes.

The pharmacy stored medicines in an orderly manner and in their original packaging. The dispenser demonstrated how date checking was managed through recording details of checks on an electronic record. The team annotated details of opening dates on bottles of liquid medicines. Several packets of date expired nitrofurantoin capsules and tablets were found during random checks of dispensary stock. The expiry dates on the expired medicines were clearly highlighted to prompt additional checks during the dispensing process. And team members checked expiry dates further during the dispensing process. No other out-of-date medicines were found during random checks of dispensary stock. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in secure cabinets. Medicines storage inside the cabinets was orderly. CD prescriptions were highlighted to prompt additional checks. For example, a check of the 28-day validity period of the prescription. The pharmacy's fridge was clean and a sufficient size for the amount of stock held. Temperature records confirmed that it was operating between two and eight degrees Celsius. But the record for December 2019 had some gaps in daily recording. Records either side of these gaps were within two to eight degrees Celsius as required.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And pharmacy team members manage and use equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date written reference resources. These included the British National Formulary (BNF) and BNF for Children. Limited internet access provided further reference resources. Computers were password protected and faced into the dispensary. This prevented unauthorised access to information displayed on computer monitors. Pharmacy team members used NHS smart cards to access people's medication records. The pharmacy stored bags of assembled medicines within the dispensary. Details on bag labels could not be viewed from the public area.

The pharmacy had a range of clean, crown stamped measuring cylinders available for measuring liquid medicines. It stored cylinders for use with methadone separately. Counting equipment for tablets and capsules was available. This included a separate triangle for use with cytotoxic medicines. It held equipment to support the flu vaccination service in a safe and accessible place, including adrenaline supplies for the treatment of anaphylactic shock. A blood pressure machine in the consultation room was several years old. The RP explained how this was used for screening purposes only. Some out-of-date equipment which the pharmacy no longer used was found in a cupboard within the consultation room. For example, blood glucose testing strips. The equipment was removed and brought to the attention of a team member. Electrical equipment contained details of portable appliance testing checks carried out in May 2019.

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.