General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, Elliott Chapel Health Centre, 215 Hessle Road, HULL, HU3 4BB

Pharmacy reference: 1117509

Type of pharmacy: Community

Date of inspection: 22/03/2024

Pharmacy context

This community pharmacy is in a large health centre in a suburb of Hull. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It supplies several people with their medicines in multi-compartment compliance packs to help them take their medication correctly. And it delivers medicines to some people's homes. The pharmacy provides other NHS services including the Pharmacy First Service and the hypertension case finding service.

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
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 suitably identifies and manages the risks associated with its services. It has written procedures that the pharmacy team follows, and it completes the records it needs to by law. The pharmacy protects people's private information, and it provides team members with training and guidance to help them respond correctly to safeguarding concerns to help protect vulnerable people. The team members respond appropriately when mistakes happen by identifying the cause and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of services. Team members had signed the SOP signature sheets to say they'd read, understood and would follow them. They demonstrated a clear understanding of their roles and worked within the scope of their role.

Team members were asked to find and correct errors spotted at the final check of a prescription. The pharmacy kept records of these errors known as near miss errors and they were completed by the pharmacist after speaking to the team member involved. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. This included completing an online report. All team members were informed of the dispensing incident so they could learn from it and were aware of the actions taken to prevent such errors from happening again. No formal reviews of the near miss records and dispensing incidents was completed to identify patterns. However, team members highlighted potential risks such as medicines that looked alike and sounded alike. For example, one team member had highlighted to colleagues that metformin and memantine had similar packaging. And to reduce the risk of dispensing the wrong medication they had separated the two products on the storage shelves. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. But there was no information in the pharmacy or on the pharmacy's website to provide people with details on how to raise a concern.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drugs (CD) registers met legal requirements. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. The pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. A random balance check undertaken during the inspection was correct. The team highlighted prescriptions for CDs to prompt them to ask the pharmacist for a second check of the completed prescription before it was handed to the person. And to remind them to put the prescription in a dedicated basket for the pharmacist to make the entry in the CD register. This process helped to ensure the person received the correct medication and to ensure all entries were made in the register. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacists to provide medication such as antibiotics. But they had not been signed by the pharmacists to show they had read them, understood them and would follow them.

The pharmacy's website displayed details on the confidential data kept and how it complied with legal requirements. It also displayed a separate privacy notice. Team members team had completed training

about the General Data Protection Regulations (GDPR). They separated confidential waste and they regularly shredded it onsite using a shredder. The pharmacy had safeguarding procedures and guidance for the team to follow to help protect vulnerable people. And team members had completed training relevant to their roles. Team members took appropriate action when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the appropriate range of experience and skills to safely provide its services. Team members work well together and are good at supporting each other in their day-to-day work. They discuss ideas and implement new processes to enhance the safe and effective delivery of the pharmacy's services. Team members have opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist manager and locum pharmacists covered the opening hours. The pharmacy team consisted of two full-time dispensers, two full-time pharmacy apprentices, a team member who had recently started working at the pharmacy and a part-time delivery driver. The pharmacy apprentice training included dispensing and selling over-the-counter medicines. The trainees had protected time at work to complete their studies and they received support from the experienced team members to help their learning. At the time of the inspection all team members were on duty.

The team had faced some staffing challenges in the previous few months after some team members left. And the pharmacist manager had been working at other pharmacies in the company providing support to other pharmacy teams. The team had also experienced an increased workload following the closure of a local pharmacy. Team members worked very well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. They held regular meetings and team members could suggest changes to processes or new ideas of working. For example, introducing the process of highlighting prescriptions for CDs so a second check of the completed prescription could be made before it was handed to the person. And to prompt team members to place the prescription in a dedicated basket for the pharmacist to make the entry in the CD register.

The pharmacy provided some additional training for team members through e-learning to keep their knowledge up to date. And they had some protected time at work to complete the training. However, most training was limited to regulatory training and learning from errors. Team members were trained or being trained on using the blood pressure monitor so they could help the pharmacist with the NHS hypertension case finding service. Team members received formal performance reviews so they could identify opportunities to develop their knowledge and skills.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are generally clean, secure and suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy team kept the premises tidy and suitably hygienic. There were separate sinks for the preparation of medicines and hand washing. Alcohol gel was also available for hand cleansing. The sink in the dispensary had not been fully cleaned after the team had washed-out the measuring cylinders used for measuring methadone liquid. Some residue from the methadone liquid was left around the sink area. Team members kept the work surfaces in the dispensary tidy and they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The pharmacy had three soundproof consultation rooms, though only two were used for private conversations with people and when providing services. The other consultation room was used as an office and storage area. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible and help people to meet their healthcare needs. Team members manage the pharmacy services safely and effectively to help make sure people receive medicines when they need them. They obtain medicines from reputable sources, and they adequately store and carry out checks on medicines to ensure they are in good condition and appropriate to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance and an automatic door. Team members asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the most suitable product was supplied. And they knew when to refer requests to the pharmacist. The NHS hypertension case finding service was popular and had resulted in some people with undiagnosed hypertension being referred for further tests. The NHS Pharmacy First service was popular and several people had presented since its launch. The pharmacist advised people when they did not meet the criteria for the service and referred them to the GP team.

The pharmacy provided medicines in multi-compartment compliance packs to help several people take their medicines. To manage the workload the team divided the preparation of the packs across the month. And ordered prescriptions in advance to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times which team members referred to during the dispensing and checking of the packs. The team did not record the descriptions of the medicines within the packs and did not always supply the manufacturer’s packaging leaflets. This meant people did not have information to help them identify the medicines in the packs and details about their medication.

The computer on the pharmacy counter had access to the pharmacy’s electronic patient records (PMR). So, when a person presented the team member could check what stage of the process their prescription was at. The team provided people with clear advice on how to use their medicines. And there was a dedicated section for storing completed prescriptions that needed the pharmacist to speak to the person when their medication was handed over. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the requirement to supply original manufacturer's packs of valproate. The pharmacist spoke to people prescribed valproate who were identified as meeting the criteria to ensure they were on a pregnancy prevention programme and they had appropriate advice and support.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people’s medicines and prescriptions to help prevent them becoming mixed up. Pharmacy team members initialled ‘dispensed by’ and ‘checked by’ boxes on dispensing labels, to record their actions in the dispensing process. When the pharmacy didn’t have enough stock of someone’s medicine the person was informed and the PMR highlighted to show the prescription was incomplete. These prescriptions were kept in a separate section so the team could prioritise completing the prescription when the medication arrived from the wholesaler. The pharmacy kept a record of the delivery of medicines to people for team members to refer to when queries arose.

The pharmacy obtained medication from several reputable sources. The pharmacy team checked the expiry dates on stock and kept a record of this. The team members generally marked medicines with a short expiry date to prompt them to check the medicine was still in date. Occasionally they didn't mark medicines with a short expiry date but moved them to the front of the shelf so they would be picked first. This ran the risk that the expiry date may be reached before the medicine was dispensed. And without a marking on the medicine's packaging there wouldn't be anything to prompt the team to check the expiry date. No out-of-date stock was found. The team checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. However, the readings were the same each day. This was discussed with team members who advised the thermometer was usually reset each time to ensure the readings were accurate. The pharmacy had medicinal waste bins to store out-of-date medicine stock and returned medication. And it stored out-of-date and returned CDs separate from in-date CDs in secure cabinets. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. These were read and appropriate action taken before they were filed away.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date information. There was equipment available for the services provided which included a range of CE equipment to accurately measure liquid medication. And a large fridge for holding medicines requiring storage at this temperature. The pharmacy had appropriate BP measuring equipment for the NHS hypertension case finding service. And it kept in-date adrenaline injections in the consultation room in the event of a person having an anaphylactic reaction when providing vaccination services. The pharmacy's computers were password protected and access to people's records were restricted by the NHS smart card system. Team members used cordless telephones to ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary which had restricted public access.

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.