General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, Unit E School Lane, Kingswood, HULL, HU7 3JQ

Pharmacy reference: 1123746

Type of pharmacy: Community

Date of inspection: 14/09/2022

Pharmacy context

This community pharmacy is in a large housing estate in Hull. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medication. The pharmacy provides the seasonal flu vaccination service and the NHS hypertension case finding service.

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 generally identifies and manages the risks associated with its services. It has written procedures for the team to follow to help ensure the pharmacy's services are provided safely. The pharmacy protects people's private information and it keeps the records it needs to by law. The pharmacy team members respond appropriately when errors happen. They identify the cause and they act to prevent future similar errors.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs had review dates of January 2021 but this had not been completed. The team had read and signed the SOPs signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure for the team to follow when an error occurred during the dispensing of prescriptions. The team kept an electronic record of the errors. A sample of these records showed some detail about the error and the actions taken to prevent a similar error from happening again. The pharmacist manager had used the information from the records to remind the team to complete a second check of the medicines they'd dispensed before passing them to the pharmacist to check. The pharmacy procedure for capturing errors that reached the person included making an electronic record. The team members were not initially able to locate any completed reports to demonstrate this had happened. The records were eventually located within the pharmacy's electronic patient medication record (PMR) for the person involved. The team members discussed the error and the learning from it. They also created a note on the person's PMR detailing the error which flashed up when the record was accessed. This was used to remind the team of the error and to check the medicines dispensed. The team highlighted to each other medicines that looked and sounded alike (LASA) so they were alert to the risk of picking these in error. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. But it didn't provide people with information on how to raise a concern with the pharmacy team.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacist regularly checked the balance of CDs to spot errors such as missed entries. The pharmacy had a book to record CDs returned by people for disposal. The pharmacy had a SOP covering data protection and managing confidentiality. The company website displayed a privacy policy for people to read. The team separated confidential waste for shredding onsite.

The pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The pharmacy didn't have safeguarding procedures for the team members to follow but the pharmacist provided guidance to them. This meant they knew when to raise a concern and described an example of the actions they had taken.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with an appropriate range of skills and experience to support its services. Team members work well together and support each other in their day-to-day work. They frequently discuss ideas to enhance the delivery of the pharmacy's services. Pharmacy team members receive some feedback on their performance and they have limited opportunities to complete ongoing training. This means they may find it harder to keep their knowledge and skills up to date.

Inspector's evidence

A full-time pharmacist manager and locum pharmacists covered the opening hours. The pharmacy team consisted of a full-time dispenser, a full-time pharmacy apprentice and a new team member. The small team worked well together. The pharmacist manager and dispenser often supported the pharmacy team at another pharmacy in Hull owned by the company. On a few occasions the pharmacy had opened late when the pharmacist manager was at the other pharmacy as a locum pharmacist was not available. The team knew what actions to take on these occasions.

The pharmacy apprentice had some protected time at work to complete their training. The pharmacy didn't provide team members with opportunities to complete additional training. The pharmacist manager advised team members of new services but there was no further training provided. The pharmacy had several months earlier completed a formal performance review with the full-time dispenser but there was no follow-up meeting to review the matters discussed. The qualified dispenser had expressed interest in developing their skills and additional qualifications but this hadn't happened.

The team regularly discussed how the pharmacy provided its services and were encouraged to suggest new ideas of working. For example, the dispenser had introduced a system to separate incomplete prescriptions depending on stock availability. Prescriptions waiting for stock shown to be available were separated from prescriptions for medicines the manufacturer could not supply. This meant the team could easily locate the prescriptions to be completed and manage the long-term supply issues such as contacting the prescriber for an alternative product. The dispenser had also rearranged the area where completed prescriptions were held to enable the team to easily locate the prescription when the person presented at the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were tidy and hygienic, it had separate sinks for the preparation of medicines and hand washing. The pharmacy had enough storage space for stock and assembled medicines. It had a defined professional area where items for sale were healthcare related. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had a large, soundproof consultation room which the team used for private conversations with people and when providing services such as the flu vaccination. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it suitably manages its services to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and it stores them properly. The team generally carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and completed an audit of people prescribed valproate products to identify anyone who met the PPP criteria. The pharmacy didn't have anyone who met the criteria. The pharmacist used the PMR to record information from conversations they had with people prescribed high-risk medicines. The team ordered repeat prescriptions for some people they identified needed this support. The team ordered the prescriptions in time for them to be dispensed and kept a record when the prescription was ordered. The NHS hypertension case finding service was popular. A few people had been referred by the local GP team and the team identified several people when dispensing their prescriptions to invite to have their blood pressure taken. The pharmacist manager was a trained vaccinator and provided the seasonal flu vaccination service against up-to-date patient group directions (PGDs). These gave the pharmacist the legal authority to administer the vaccines.

The pharmacy provided multi-compartment compliance packs to help a few people take their medicines. The team members ordered the prescriptions in advance of supply to allow time to deal with issues such as missing items. The team recorded the descriptions of the medicines within the packs and supplied the manufacturer's packaging leaflets. So, people could identify the medicines in the packs and to have information about their medicines. The pharmacy received copies of hospital discharge summaries which the team checked for changes or new items.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription, however, a sample of completed prescriptions found only the checked by box was completed. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The team used a barcode system to identify from the PMR the different stages the prescription was at so they could readily locate it when someone presented at the pharmacy for their prescription.

The pharmacy obtained medication from several reputable sources. The pharmacy team regularly checked the expiry dates on stock but didn't keep a record of this activity. The team members usually marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The team members mostly recorded the dates of opening on medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day. A sample of these records found they were

within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. 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. The team actioned it and usually kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and to suitably protect people's confidential information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided, this included a range of CE equipment to accurately measure liquid medication. The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the computer on the pharmacy counter in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view and it held private information in the dispensary and rear areas, 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.