General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jhoots Pharmacy, 15 McDonald Court, Hatfield, Hertfordshire, AL10 8HR

Pharmacy reference: 9012128

Type of pharmacy: Community

Date of inspection: 15/10/2024

Pharmacy context

The pharmacy is on a small shopping precinct in a largely residential area. It provides NHS dispensing services, the New Medicine Service and blood pressure checks. It supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people. This was the pharmacy's first inspection since opening around 18 months ago following a relocation.

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 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 not all met	4.3	Standard not met	The pharmacy does not have an adequate expiry date routine. This could increase the risk of people getting medicine which is past its 'use-by date'. It does not always store medicines in accordance with relevant legislation. This makes it harder to show that they are kept securely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It largely protects people's personal information. And it mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. But it doesn't review mistakes that happen during the dispensing process. And this could mean that the pharmacy is missing out on opportunities to learn and improve its services. People can provide feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people.

Inspector's evidence

Team members had signed the pharmacy's up-to-date standard operating procedures (SOPs) to show that they had read, understood, and agreed to follow them. And their roles and responsibilities were specified in them. The dispenser explained that the pharmacy would open if the pharmacist had not arrived in the morning. She knew which tasks should only be undertaken if there was a responsible pharmacist (RP) signed in. And she knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacist explained that near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. The pharmacist showed where the near misses were recorded on the pharmacy's computer. He confirmed that the near misses record had not been reviewed for patterns. This could limit the pharmacy's ability to help minimise the chance of similar mistakes happening again. The pharmacist said that he was not aware of any recent dispensing errors, where a mistake had happened, and the medicine had been supplied to a person. He explained that these would be recorded on the pharmacy's computer.

The pharmacy had current professional indemnity insurance. The pharmacist said that the pharmacy did not supply pharmacy-only medicines in an emergency without a prescription. He said that people were referred to their GP or NHS 111. The private prescription records were largely completed correctly, but the prescriber's details and date on prescription were not always recorded. And this may make it harder for the pharmacy to find this information in the future. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not recorded. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The correct RP notice was clearly displayed, and the RP record was completed correctly.

Confidential waste was shredded, computers were password protected and people using the pharmacy could not see information on the computer screens. Team members used their own smartcards to access the NHS spine during the inspection and they said that these were stored securely when not being used. Some people's personal information on bagged items waiting collection could potentially be viewed by people using the pharmacy. The dispenser turned them round during the inspection so that any personal information could not be seen.

The pharmacist said that there had not been any recent complaints. He said that he attempted to resolve any complaints in the pharmacy and informed the pharmacy's head office if needed. The

complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website.

Team members had completed training about protecting vulnerable people. And the pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The dispenser described potential signs that might indicate a safeguarding concern and said that she would refer any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They complete the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can raise concerns about the pharmacy or other issues affecting people's safety to the relevant organisations or the pharmacy's head office.

Inspector's evidence

There was one pharmacist and one trained dispenser working during the inspection. There was a team member working at the start of the inspection who left shortly after the inspector arrived at the pharmacy. The pharmacist explained that he was a first-year pharmacy student. Holidays were staggered to ensure that there were enough staff to provide cover. And cover could be requested from nearby pharmacies if needed. Head office could be contacted to arrange pharmacist cover if needed. The pharmacist and dispenser worked well together and communicated effectively during the inspection. And the pharmacy was up to date with its dispensing.

The dispenser appeared confident when speaking with people using the pharmacy. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care. And she was aware of the restrictions on sales of medicines containing pseudoephedrine. She asked people relevant questions to establish whether the medicines were suitable for the person they were intended for.

The dispenser said that she had access to online training modules and could completed these at work during quieter periods at work or at home. She said that she had to undertake an assessment after each module and was provided with certificates. She also said that she read pharmacy-related magazines to help keep her knowledge up to date. The pharmacist was aware of the continuing professional development requirement for professional revalidation. He said that he had recently attended a webinar about the flu vaccination service.

The pharmacist said that he felt able to make professional decisions. The dispenser explained that she had ongoing informal performance reviews and formalised ones yearly. The pharmacist and dispenser said that they discussed any issues as they arose and discussed task priorities each morning. The pharmacist explained that he attended monthly conference calls with other pharmacies in the company. And that targets were not set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

There was seating in the shop area for people waiting for services. The pharmacy had four rooms in the shop area. The pharmacist said that three were used for storage and one was used as a consultation room. The rooms were not lockable and there were some waste medicines stored in one of the rooms. The consultation room was accessible to wheelchair users, suitably equipped and well screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

The pharmacy was secured against unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not have a reliable date checking routine and it doesn't always store its medicines in accordance with relevant legislation. But it gets its medicines from licensed wholesalers, and it responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was step-free access into the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. And the pharmacy could produce large-print labels for people who needed them. There was no signage at the front of the pharmacy and the pharmacy did not appear on Google maps, so it was not easy to find. The premises the pharmacy had moved from was still showing. And the pharmacy's address did not appear on the pharmacy's website. The pharmacist said that he would discuss these with the pharmacy's head office.

Team members initialled dispensing labels when they dispensed and checked each item to show who had completed these tasks. And they used baskets were used to minimise the risk of medicines being transferred to a different prescription. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter.

The dispenser said that prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as warfarin. And the pharmacy kept a record on the patient's medication record. He said that the local surgery would not issue a prescription if the person did not have up to date blood test results available. Prescriptions for Schedule 3 and 4 CDs were highlighted which helped to minimise the chance of these medicines being handed out when the prescription was no longer valid. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy dispensed these medicines in their original packaging. And the pharmacist said that they would refer people to their GP if they needed to be on the PPP and weren't on one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacist said that drug alerts and recalls were received from the pharmacy's head office, the NHS and the MHRA. He explained the action the pharmacy took in response to any alerts or recalls. But said that the pharmacy did not keep a record of any action taken. So, it may make it harder to demonstrate appropriate action had been taken in the event of a concern or query. He agreed to keep a record in future. The fridge was suitable for storing medicines and it was not overstocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range.

Stock was stored in an organised manner in the dispensary. Short-dated medicines were not highlighted and there were several expired medicines found in with dispensing stock during a random spot check.

The pharmacist said that the pharmacy had not carried out expiry date checking since opening, but he routinely checked the expiry date of a medicines before they were supplied to people. He said that there had not been any dispensing errors reported to the pharmacy where an expired medicine had been supplied. There were several loose blisters found with dispensing stock and some did not show the medicine's batch number or expiry date. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. There were some expired CDs found with dispensing stock during a spot check. The pharmacist said that there had not been any patient returned CDs since the pharmacy had opened. When questioned, he explained that he would keep a record and ensure that these were destroyed appropriately. The pharmacist provided assurances that a robust date checking routine would be implemented. Denaturing kits were available for the safe destruction of CDs. However, CDs were not always stored in accordance with legal requirements.

The dispenser regularly checked uncollected prescriptions and people were contacted if they had not collected their items after three months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. The pharmacist explained that the pharmacy did not dispense prescriptions if they could not be supplied in full. He said that the pharmacy signposted people to other pharmacies or back to their GP if the item could not be obtained from the supplier. The pharmacist said that the pharmacy could print 'owings' notes if needed and give these to the patient. And prescriptions for alternate medicines were requested from prescribers where needed.

The pharmacy supplied medicines in multi-compartment compliance packs to some people. A suitability assessment was completed by the person's GP to identify which medicines were needed to be dispensed into the packs. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. And prescriptions for 'when required' medicines were not routinely requested. The pharmacist said that people usually contacted the pharmacy if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines. Patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacist said that some people had insisted that they did not want them, but the pharmacy had not made a record to show this. The importance of providing patient information leaflets was discussed with the pharmacist during the inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

A glass measure was available for measuring liquids but not for volumes less than ten millilitres. The pharmacy had been using plastic measures for certain liquids. The pharmacist said that he would order suitable measures. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around 18 months. The pharmacist provided assurance that it would be replaced in line with the manufacturer's guidance. The weighing scales and the shredder were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.