General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jardines (U.K.) Ltd, 306-308 Oakley Road, Leagrave, LUTON, Bedfordshire, LU4 9QD

Pharmacy reference: 1028881

Type of pharmacy: Community

Date of inspection: 29/02/2024

Pharmacy context

The pharmacy is in a parade of businesses in a mixed commercial and residential area in Luton. It sells medicines over the counter and provides health advice. The pharmacy dispenses private and NHS prescriptions. It supplies medicines in multi-compartment compliance packs for people who have difficulty managing their medicines. Its other services include delivery, blood pressure case-finding, seasonal flu, supplying COVID-19 lateral flow tests (eligible NHS patients) and Pharmacy First

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's working practices are generally safe and effective. It has suitable written instructions for members of the team to follow. But it does not always retrain them when it reviews its procedures. So they may not be aware of current best practice with providing pharmacy services. Team members learn from their mistakes and take action to prevent the same thing happening again. The pharmacy mostly keeps the records it needs to by law to show it supplies its medicines and services safely. Members of the pharmacy team protect people's private information, and they understand their role in safeguarding the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The pharmacy team members discussed their mistakes to learn from them by taking action and reducing the chances of the same thing happening again. They described how medicines involved in incidents, or were similar in some way, such as different strengths of propranolol were separated from each other in the dispensary as the packs were so alike. The pharmacy's medicines stock was generally arranged in alphabetical order. A member of the team explained how the team checked the differences in formulation of calcium preparations to help make sure they picked the one that was prescribed. The pharmacy had a complaints procedure, and the team could report incidents to the superintendent pharmacist (SI) in head office.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medicines and to help them prioritise their workload. They checked interactions between medicines prescribed for the same person with the pharmacist. And assembled prescriptions were not handed out until they were checked by the pharmacist. Team members who prepared and checked prescriptions initialled the dispensing labels to create an audit trail. They attached warning stickers to highlight prescriptions for high-risk medicines. For instance, controlled drugs (CDs) prescriptions which were only valid for 28 days. And they supplied warning cards such as for warfarin or prednisolone to make sure people had all the information, they needed to use their medicines effectively. Team members recorded interventions such as the outcomes for a new medicines service consultation on the patient medication record (PMR) or PharmOutcomes. Members of the team who handed out prescriptions confirmed the person's details on the address label on the prescription bag and checked the date of birth if needed. The pharmacy no longer printed people's repeat prescriptions.

The pharmacy had recently reviewed standard operating procedures (SOPs) for its services, responsible pharmacist (RP), and team health and safety. But they were not all filed securely in the folder and were mixed up with older SOPs which could have been archived. Some team members had not retrained in more recently reviewed SOPs.
Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. A member of the team described the sales protocol for recommending over-the-counter (OTC) medicines to people and a sales protocol poster was displayed near the medicines counter. The team members knew what they could and could not do, what they were responsible for and when they should seek help. They explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated

requests for the same or similar medicines, such as medicines liable to abuse to a pharmacist. The pharmacy received feedback from people verbally, and via a NHS patient experience survey for which a QR code was displayed.

The pharmacy team had completed a risk-assessment of the pharmacy and the consultation room to make sure it was ready to provide the seasonal flu vaccination service. And the team members had completed pharmacy quality scheme (PQS) audits to identify people who required more information about how to use their medicines more effectively. For instance, they identified people prescribed asthma inhalers, checked their inhaler technique and if they had a spacer. The team completed an audit of people prescribed antibiotics to make sure they followed the dosage instructions and understood their side effects. And the audit of anticoagulants identified people with no warning card. The pharmacy team had completed a clinical audit of people taking valproates and they were aware there were new rules when dispensing a valproate. Planning audits to monitor different parts of the Pharmacy First service was discussed such as diagnosis, compliance with the patient group direction (PGD) pathway and signposting.

The pharmacy displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It maintained a controlled drug (CD) register and CDs were audited to check how much stock it had of each CD. A random check of the actual stock of a CD matched the amount recorded in the register. The pharmacy kept records for the supplies of unlicensed medicines it made and the private prescription records were generally complete. The RP provided travel vaccinations which were administered via PGDs recently been renewed. And records of each vaccine included the person's details, the vaccine details such as batch number and expiry date and when they were administered. The pharmacy team recorded the daily fridge temperatures.

The pharmacy team members had completed general data protection regulation training. They tried to make sure people's personal information was disposed of securely. Members of the team used their own NHS Smartcards. And they had trained in SOPs for accessing summary care records (now known as national care records) and information governance.

The pharmacy had a safeguarding procedure. The RP had completed level 3 safeguarding training. And the team had completed safeguarding training in line with the PQS requirements. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. And the pharmacy team was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s team members are qualified or in training for the roles they have. Members of the team work well together to manage their workload. They can provide feedback and know how to raise concerns relating to the pharmacy's services.

Inspector's evidence

The pharmacy team consisted of the RP and regular locum pharmacists to cover Fridays, one full-time and two part-time dispensing assistants, two part-time medicines counter assistants and a full-time delivery driver. Team members were enrolled on or had completed accredited training. A work-experience student on placement at the time of the visit. A dispenser had applied to enter the Overseas Pharmacists' Assessment Programme.

The pharmacy mostly relied upon its team to cover absences. The pharmacy team members were signposted to the GPhC knowledge hub. The RP described training completed to deliver the Pharmacy First service such as using the equipment, reading through the SOPs, the patient group directions (PGDs) and the guidelines. The master authorisation sheet was signed and retained with other Pharmacy First documentation. Members of the team had completed training required for the pharmacy quality scheme (PQS), such as protecting the welfare of vulnerable people. And they had read SOPs for manual handling, health and safety and avoiding slips, trips and falls.

Members of the pharmacy team worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an OTC sales and self-care SOP which described the questions the team member needed to ask people when making OTC recommendations. And when they should refer to the RP. The RP organised regular team meetings to plan the day’s activities or tell the team about training they needed to complete. And members of the team were able to feedback how they could improve pharmacy services to the RP. They had suggested how they could improve they organised preparation of compliance packs. And team members could raise concerns through the whistleblowing SOP. The pharmacy team could communicate via WhatsApp.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are bright, clean and secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed to protect people's private information and to keep its medicines stock safe. People can have a private conversation with a team member in the consultation room.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure although there were older fixtures and fittings. There were chairs for people who wanted to wait. And action had been taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a retail area and a medicines counter where people could buy medicines or other sundry items. The dispensary was to one side behind the retail area and there was a room opposite where members of the team prepared compliance packs. There was room for storage. The pharmacy had a consultation room which was signposted, clean and tidy where people could have a private conversation with a team member. There was a chaperone policy SOP. Team members kept worksurfaces clear to help avoid becoming cluttered when the pharmacy was busy. Members of the pharmacy team were responsible for keeping the pharmacy's premises clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and its services are easily accessible to people with a variety of needs. And it generally provides its services safely and effectively. The pharmacy obtains its medicines from reputable sources so that they are fit for purpose. It stores them securely at the right temperature to help make sure they are safe to use. People are provided with the information they need to use their medicines properly. The pharmacy team members respond to medicine alerts and recalls to help make sure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy had a manual door and a slight step at the entrance from the pavement. The team tried to make sure people with different needs could access the pharmacy services. The pharmacy displayed its opening hours and service information at the front entrance. There was seating available for people who were waiting. Members of the pharmacy team were helpful. They could speak or understand Urdu and Punjabi to assist people whose first language was not English. They could print large font labels, so they were easier to read. And they signposted people to another provider if a service was not available at the pharmacy. Such as the local general practitioner or NHS 111. The RP was in a Luton area WhatsApp group with other pharmacies and clinical pharmacists to source information about services and medicines elsewhere. People could return old inhalers to the pharmacy's used inhaler box on the medicines counter.

The pharmacy had a business continuity plan to help manage services in the event of a systems failure or staff illness. It had a back-up to power the pharmacy computer for a number of hours. The pharmacy's delivery person delivered medicines for people who could not attend the pharmacy in person and maintained an audit trail to help show the medicines had been delivered to the correct person. The delivery person had not signed the delivery procedure but may have trained and signed the SOP at the pharmacy's head office. The pharmacy had installed a collection point vending machine situated on its perimeter so people who had signed up to this service could collect their medicines outside opening hours using a unique six-digit PIN. A small number of collection-point prescriptions containing medicines which required monitoring or counselling were highlighted, and the issue of making sure the monitoring and counselling were provided was discussed.

The pharmacy supplied medicines in disposable multi-compartment compliance packs for people who had difficulty taking them on time. The pharmacy team re-ordered prescriptions for these people and checked them for changes in medicines since the previous time. Members of the team said they would make sure medicines were suitable to be re-packaged if necessary. They provided a brief description of each medicine contained in the compliance packs but did not always provide patient information leaflets (PILS). So, moving forward, they gave assurances that they would supply PILs with each set of packs to help ensure people had the information they needed to take their medicines safely. High-risk medicines were generally supplied separately to the compliance pack. The team prepared and delivered compliance packs for people in care home settings. It liaised with the care home and the surgery. And it supplied medicines administration record charts to representatives of people who received compliance packs and provided counselling on medicines. Following a hospital stay, the pharmacy sometimes received a discharge summary and if prescriptions were incorrect, the RP emailed the surgery to

arrange another prescription.

Members of the team initialled dispensing labels so they could identify who prepared a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting. The RP counselled people on how best to use their medicines and supplied warning cards for high-risk medicines such as steroids. For people taking warfarin, the RP checked the INR was monitored and recorded the value on the PMR. The RP reminded people about foods and medicines which may affect their INR. The RP and the pharmacy team members were aware of the new up-to-date guidance and rules for supplying valproate-containing medicines which must always be dispensed in the manufacturer's original full pack. And no-one under the age of 55 – both men and women - should be started on a valproate unless two specialists independently agree and document that there is no other safe and effective medication, or that there are compelling reasons why the reproductive risks linked to valproate, do not apply.

The RP had liaised with the local surgery and clinical pharmacist ahead of commencing the Pharmacy First service. In preparation, the RP had completed training and the SOP set out the training and operational requirements, and the clinical pathways. Treatment was recorded on PharmOutcomes. The pharmacy team had been asked to alter their work pattern to help accommodate the service. The RP had collated information on conditions which could be treated, people who were suitable to treat and red flags for those who were not and should be referred elsewhere. The pharmacy had already treated some people through the new service. The pharmacy offered the blood pressure case-finding service. People who had accessed the new medicines service generally had follow up consultations by phone. The pharmacy offered a travel vaccination service via PGDs.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It generally kept medicines and medical devices in their original manufacturer’s packaging but there were some loose strips of medicines. Liquid medicines were marked with the date of opening. The dispensary was tidy. The pharmacy team carried out date checks of stock but the RP checked the expiry date as part of the final check of prescriptions. The pharmacy stored its stock, which needed to be refrigerated, between two and eight Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy’s waste medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the pharmacist described the actions they took and explained what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately and keeps people's private information safe.

Inspector's evidence

The pharmacy team had access to up-to-date and online reference sources. It had clean glass measures to measure liquid medicines. The pharmacy had fridges to store its pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures for each fridge. The CD cabinet was fixed securely. The blood pressure monitor was not marked with a date of opening to be sure when it was due to be serviced or replaced. There were sharps bins for vaccination sharps disposal and keeping them out of reach to avoid a needlestick injury was discussed. The pharmacy team disposed of confidential waste appropriately. The pharmacy restricted access to its computers and PMR system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure they used their own NHS smartcards.

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.