General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jardines Pharmacy, 25-27 Jansel Square, Bedgrove Estate, AYLESBURY, Buckinghamshire, HP21 7ET

Pharmacy reference: 1029079

Type of pharmacy: Community

Date of inspection: 22/10/2024

Pharmacy context

This is a community pharmacy in a residential area and on the outskirts of Aylesbury, Buckinghamshire. The pharmacy is located alongside other local shops and close to a large GP surgery. Team members dispense NHS and private prescriptions. They sell a range of over-the-counter medicines and offer seasonal flu vaccinations, blood pressure testing as well as the Pharmacy First Service. The pharmacy also supplies some people with their medicines inside multi-compartment compliance packs if they find it difficult to take them.

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 not all met	2.1	Standard not met	The pharmacy does not have enough suitably qualified and skilled staff available at all times to ensure the workload is managed safely and effectively.
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 has some systems in place to manage risks. Members of the pharmacy team understand their role in protecting the welfare of vulnerable people. Team members deal with their mistakes responsibly. But they are still not always documenting and formally reviewing the necessary details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. And the pharmacy could do more to make sure its records contain all the necessary details.

Inspector's evidence

Members of the pharmacy team understood their roles well and they knew what they could or could not do in the absence of the responsible pharmacist (RP). People using the pharmacy's services could easily identify the pharmacist responsible for the pharmacy's activities as the correct notice was on display. The pharmacy team had access to a range of documented standard operating procedures (SOPs). Most of them still listed details about a pharmacist, who had been superseded since they had left the company and were dated from 2021. However, there were also some now which were seen to have been reviewed by the current superintendent pharmacist and were dated from 2023. The SOPs provided guidance for the team to carry out tasks correctly and had been read and signed by the staff.

The team processed and assembled prescriptions in different areas to the RP. Staff used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. Colour-coded baskets were used to separate acute or repeat prescriptions and highlighted priority. Once the team generated the dispensing labels, there was a facility on them to help identify who had been involved in the dispensing process. This was routinely used as an audit trail. The area where the RP accuracy-checked prescriptions from however, was packed full of baskets awaiting a final check.

Incidents were managed by RP and his process was suitable. Team members routinely recorded mistakes which occurred during the dispensing process (near-miss mistakes) and certain medicines, such as any that looked-alike and sounded-alike had been separated. However, there was no collective formal review of near miss mistakes currently occurring.

Staff had been trained to safeguard the welfare of vulnerable people. The pharmacist had been trained to level three and team members could recognise signs of concerns; they knew who to refer to in the event of a concern. However, there were no available contact details for the local safeguarding agencies. This could lead to delays in referring if concerns were seen.

The pharmacy's team members had been trained to protect people's confidential information. No sensitive details were left in the retail area or could be seen from the retail space. Bagged prescriptions awaiting collection were stored in a location where personal information was not easily visible. The pharmacy also had information on display so that people were informed on how their sensitive data was protected. However, this was in the dispensary and not visible to members of the public. Moving this to the retail area was advised during the inspection. In addition, a member of staff's NHS smart card had been left within one computer terminal and was being used during the inspection. This person was not on the premises at the time and their password was known. The RP confirmed that it had been left

in overnight, he removed it when highlighted and replaced it with his own. Upon reflection he accepted that individual passwords should not be shared and that they should be changed if necessary. This practice limits the pharmacy's ability to control access to people's confidential information.

The pharmacy had suitable professional indemnity insurance arrangements in place. Records of controlled drugs (CDs) were compliant with statutory and best practice requirements. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. The RP record, records of emergency supplies and unlicensed medicines were also complete. However, there was a concern noted with the pharmacy's CD destruction register which held details about CDs returned by people for destruction. In addition, within the electronic register for supplies made against private prescriptions, incorrect prescriber details had been consistently recorded. This included private prescriptions for CDs.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not do enough to ensure it is always adequately staffed. Team members are unable to focus on their individual tasks without being constantly interrupted. And the pharmacy doesn't give them enough time or sufficient resources for their ongoing training needs. But they work well together and support one another. Team members have a clear understanding of their roles and know when to seek help or refer to the pharmacist.

Inspector's evidence

There were two dispensing assistants, and a locum pharmacist on duty at the inspection. Both dispensing assistants were fully qualified for their roles. One was employed full-time and the other part-time. They were both clearly competent and were working well together. However, one was having to cover the medicines counter, receiving, and handing out prescriptions as well as responding to queries. In between this she was also trying to assemble a multi-compartment compliance pack which remained exposed on the dispensary workbench for the duration of the inspection. This risked mistakes occurring. The pharmacist was providing flu vaccinations and checking prescriptions in between. The pharmacy was very busy throughout the inspection and the team was struggling to keep on top of their workload. Towards the end of the inspection, one of the company's managers arrived to see how they were getting on with the Pharmacy First service. However, he quickly recognised that the team needed support and offered to help with checking prescriptions. One of the dispensing assistants explained that they did have a part-time accuracy checking technician (ACT) who worked for part of both Wednesdays and Thursdays. Apart from that, it was generally just the two dispensing assistants plus a pharmacist on duty. There had been some short-term cover provided but only lasted for a few days. Team members explained that they struggled to keep up with demand, especially as more people wanted to wait for their prescriptions. Their area manager visited approximately once a week.

It was evident that the team was short-staffed during the inspection. Very few people's prescriptions were ready on time for them to collect. Most people were given long waiting times and there were constantly long queues. Staff confirmed that they were behind with the workload. Aside from the dispenser who was constantly interrupted whilst she prepared a compliance pack that was due that week, the other dispenser was observed to work and assemble prescriptions at a fast pace to try and catch up. This risked and increased the likelihood of mistakes occurring. The situation seen on the day was not an isolated event as both inspectors were told that the dispensers had been left to work alone with just the RP at times with no additional assistance provided.

One of the inspector's subsequently spoke to the superintendent pharmacist (SI) to ensure she was aware of the staffing situation. The SI was aware that the pharmacy was under pressure and explained how they were trying to organise short-term cover while finding a permanent solution.

There was a training folder with health-related articles in, such as bladder weakness and joint pain. But there was no evidence to show they had been read, and the section of the file for recording training was empty. Team members explained that there was no structured training provided for them, so they kept themselves up to date in their own time. The RP confirmed that he had completed the required training for the Pharmacy First service, including how to use the otoscope. He had not been trained to use the oximeter though.

Staff members questioned were able to demonstrate an awareness of potential medicines abuse and could identify people making repeat purchases. They described how they would refer to the pharmacist if necessary. All three team members were seen to serve customers and asking appropriate questions when responding to requests or selling medicines. There were some targets in place, particularly for the Pharmacy First service, but they appeared to be managed sensibly.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a secure and professional environment for the services it provides. The pharmacy keeps its premises clean and well maintained. It has a suitable consultation room which it uses for some of its services and for sensitive conversations. The pharmacy is sufficiently secure when closed.

Inspector's evidence

The pharmacy premises had been newly refitted to a high standard. They were modern, clean, tidy, and presented a professional appearance. There were double doors into the pharmacy with step-free access making it easy for people using wheelchairs or other mobility aids. There was an automatic opening system for the door, but it was not operational at the time of the inspection. The retail area was spacious and open, allowing plenty of space for people to wait. There was a large, well laid out dispensary with workbenches around the perimeter and a central island providing sufficient space to work safely and effectively. There was a clear workflow in the dispensary and the layout was suitable for the activities undertaken. There was a cleaning rota on the wall, although this had not been completed on a regular basis. One of the dispensing assistants explained that they wiped down all work surfaces daily and swept the floor every couple of days.

There was a consultation room available for confidential conversations, consultations, and the provision of services. The door to the consultation room was kept closed but not locked when not in use, but there was no confidential information visible. There was a desk with two chairs and a laptop computer with two closed sharps bins underneath. There was also a small sink with hot and cold running water, hand cleaner and paper towels. There were notices in the consultation room setting out the conditions and eligibility criteria for the Pharmacy First service as well as prompts for the hypertension case finding service.

The dispensary sink also had hot and cold running water with handwash and paper towels available. There was a small staff rest area at the rear and a staff toilet where cleaning equipment was also stored. Room temperatures were appropriately maintained by combined air-conditioning and heating units, keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy sources its medicines from reputable suppliers and stores its medicines adequately. The pharmacy has some checks in place to ensure that medicines are not supplied beyond their expiry date. But its records to help verify this are missing. And the pharmacy does not always make enough checks to help people receiving higher-risk medicines inside multi-compartment compliance packs take their medicines safely.

Inspector's evidence

The pharmacy had a few seats available for people if they wanted to wait and car parking spaces present outside. As stated under Principle 3, people with restricted mobility or using wheelchairs could easily access the pharmacy's services. The RP had been appropriately trained to vaccinate people requiring seasonal flu and, or COVID-19 vaccinations. He had signed the PGDs to authorise this and to supply medicines under the Pharmacy First service, but they were not readily accessible in the pharmacy to verify. Suitable equipment was present which helped ensure that the service was provided safely and effectively (see Principle 5).

Staff were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). They ensured these medicines were dispensed in the original manufacturer's packs, that relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them and had previously identified people in the at-risk group who had been supplied sodium valproate.

People requiring compliance packs had previously been identified as having difficulty in managing their medicines. The pharmacy ordered prescriptions on behalf of people for this service and records were kept for this purpose. Queries were checked with the prescriber and the records were updated accordingly. Descriptions of the medicines inside the packs were provided and patient information leaflets (PILs) were routinely supplied. All medicines were removed from their packaging before being placed inside the compliance packs. However, some people with compliance packs received higher-risk medicines. They were not routinely identified, counselled, or provided with any specific advice relating to their medicines.

The pharmacy obtained its medicines and medical devices from licensed wholesalers. Short-dated medicines were identified. The team stated that they regularly checked medicines for expiry, but they could not locate any records to help verify when this had taken place. There were no date-expired medicines seen. CDs were stored securely and medicines requiring refrigeration were stored in a suitable way. Records verifying that the temperature of the fridge had remained within the required range had been appropriately completed. Drug alerts were received electronically. Staff explained the action the pharmacy took in response and relevant records were kept verifying this. Medicines returned for disposal, were accepted by staff, and stored within designated containers, except for sharps which were redirected appropriately. However, they had been stored in the staff WC. This increased risks.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for the range of services it provides. And it makes sure its team members know who to contact in the event of any technical problems.

Inspector's evidence

The pharmacy had six crown-stamped conical measures and suitable equipment for counting loose tablets and capsules. One of the counting triangles was marked for use with methotrexate only. All the necessary equipment was available for the Pharmacy's services, including a blood pressure monitor, scales, height measure, fingertip pulse oximeter and an otoscope with plenty of spare earpieces. The RP explained that they were new and that they could contact their head office if they needed to be replaced. There was also a box of adrenaline ampoules for use in case of an emergency. There were three fridges in the dispensary, with supplier contact details on the fridge doors for staff to use in case of any problems with the fridges. The consultation room was spacious, soundproof, and used for some of the pharmacy's services.

All computer screens were positioned so that they were not visible to the public and were password protected. NHS smartcards were in use, and most team members were using their own NHS smartcards. However, there was one card belonging to another team member who was not on duty that day. The RP confirmed that it had been incorrectly left in overnight and that other team members knew the password to use it. He removed it immediately and replaced it with his own. Upon reflection he accepted that individual passwords should not be shared and that they should be changed if necessary. The pharmacy made use of online reference sources such as the electronic medicines compendium and the BNF online.

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.