General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jardines Pharmacy, 5 Kingsfield Road, Saxon Centre, BIGGLESWADE, Bedfordshire, SG18 8AT

Pharmacy reference: 1095741

Type of pharmacy: Community

Date of inspection: 27/09/2023

Pharmacy context

This community pharmacy is within a parade of shops on the edge of Biggleswade, Bedfordshire. Its main services include dispensing NHS prescriptions and selling over-the counter medicines. It dispenses private prescriptions, and it provides a seasonal flu vaccination service. The pharmacy offers a medicine delivery service to people who cannot physically attend the pharmacy to collect their medicines.

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 identifies and manages the risks associated with its services adequately. It mostly keeps the records required by law. And it keeps people's confidential information secure. The pharmacy advertises how people can provide feedback about its services. And its team members use this feedback to inform change. They know how to recognise and respond to safeguarding concerns. And they engage in some conversations to help reduce risk following the mistakes they make during the dispensing process. But they do not always record these mistakes. This means there may be some missed opportunities to share learning.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to support its safe and effective running. These covered the responsible pharmacist (RP) role, controlled drug (CD) management and pharmacy services. The SOPs had been issued in June 2021 and were due for review. Team members were observed following SOPs throughout the inspection when completing tasks in the dispensary and on the medicine counter. For example, completing verbal identity checks with people collecting medicines. And they understood what tasks could not take place if the RP took absence from the premises. But not all team members had signed the SOPs to confirm they had read and understood them.

The pharmacy had processes designed to support learning following mistakes made and found during the dispensing process, known as near misses. The team recorded some of these mistakes, but records showed clear peaks and troughs in recording rates. And team members acknowledged that although they regularly discussed their mistakes, recording may not happen during busier periods. They explained how they aimed to reduce risk by using different team members to complete individual steps of the dispensing process whenever possible. And they acted to separate medicines with similar names on the dispensary shelves to reduce the risk of a picking error occurring. The team understood the need to report serious mistakes found following the supply of a medicine to a person, known as dispensing incidents. But the RP explained that less serious mistakes such as minor quantity errors were not generally reported if a person was satisfied with the way the team had managed the mistake. A discussion took place about the need to follow the pharmacy's reporting procedures which stated that all dispensing incidents should be reported. The RP acknowledged this and confirmed they knew how to report and how to seek assistance if needed from a senior pharmacist within the company.

The pharmacy had a procedure for managing concerns. A notice behind the medicine counter advertised how people could provide feedback about the pharmacy. Team members understood how to manage and escalate feedback. They explained they would always aim for local resolution of a concern wherever possible. They had introduced a new filing system which had improved the efficiency of the medicine handout process following receiving feedback about the time it took to find assembled bags of medicines. The pharmacy had a procedure to support its team members in recognising and raising concerns about vulnerable people. The RP had completed safeguarding learning through the Centre for Pharmacy Postgraduate Education. Other team members had completed some safeguarding learning. They knew how to recognise and report safeguarding concerns. A team member working on the medicine counter was aware of what steps to take if a person presented at the pharmacy using

code words associated with safety initiatives designed to support people experiencing domestic violence.

The pharmacy had current indemnity insurance. The RP notice was updated at the beginning of the inspection to display the correct details of the RP on duty, this was shortly after the pharmacy had opened. The RP record was generally completed in full; occasional records did not have the sign-out times of the RP. Details of the prescriber were missing from some entries within the electronic Prescription Only Medicine (POM) register. The pharmacy generally held its CD register in accordance with legal requirements. But wholesaler addresses were not regularly entered into the register when entering the receipt of a CD. The pharmacy maintained running balances within the CD register. A recent full balance check of CDs against physical stock had occurred. But these checks were infrequent, and the team reflected on the time it took them to resolve a discrepancy found during the most recent balance check. A range of balance checks took place during the inspection. There was a discrepancy between the register and physical balance of the first CD checked. All other checks completed complied with the running balance in the CD register. An investigation into the discrepancy following the inspection was undertaken and the cause of the discrepancy was identified. The pharmacy held people's personal information on password protected computers and within the staff-only part of the premises. Team members understood the need to keep people's personal information safe and secure. They separated confidential waste, and this was collected periodically for secure disposal.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team of suitably skilled and knowledgeable people who work together well to provide its services. Pharmacy team members demonstrate enthusiasm for their roles. They engage in discussions and learning relevant to the tasks they undertake. And they understand how to raise concerns at work.

Inspector's evidence

The RP was a regular locum pharmacist who covered many of the pharmacy's opening hours. Two qualified dispensers, two trainee medicine counter assistants and a delivery driver were on duty during the inspection. The pharmacy also employed a trainee dispenser. There was no regular reliance on obtaining support from other local pharmacies within the company to support with leave arrangements. Instead, team members worked flexibly and planned leave carefully to avoid multiple people being absent from work at any given time. Workload was managed and was up to date. Pharmacy team members were observed working together well and managed queries efficiently through clear communication. The pharmacy had some targets to support the delivery of its services. Team members expressed they were supported in concentrating on NHS essential services during busier periods. The RP felt able to apply their professional judgment when delivering the pharmacy's services.

One trainee medicine counter assistant had yet to start a GPhC accredited training course. They were in the last stages of their induction programme and were seen to be well supported by other team members. Another trainee was progressing through their learning well with support provided by the wider team and regular RP. All team members engaged in ongoing learning relevant to their roles. For example, antimicrobial stewardship learning. One of the dispensers had successfully completed their vaccination training and was due to support the delivery of the pharmacy's flu vaccination programme. The pharmacy did not have a structured appraisal process. So, there may be fewer opportunities for team members to discuss and seek support with their learning and development needs.

The pharmacy team communicated through regular informal conversations. But it did not record the outcome of conversations about patient safety. This meant opportunities to share learning and to measure the impact of any risk reduction actions taken were reduced. The pharmacy had a whistle blowing policy. Pharmacy team members knew how to raise concerns at work, and they were confident in following the company's reporting processes. A team member provided details of how they had escalated a serious concern to a senior manager. And immediate action was taken to reduce risk following this escalation.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and secure. They provide a professional image for the delivery of healthcare services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and well maintained. Team members knew how to report maintenance concerns and confirmed there were no current maintenance issues. The pharmacy was clean and relatively tidy. Lighting was adequate and air conditioning helped to provide an ambient environment for the storage of medicines and the delivery of pharmacy services. Pharmacy team members had access to sinks equipped with appropriate hand washing materials. A sink in the dispensary was primarily used to reconstitute liquid medicines. The public area was a decent size, and it was open plan which meant it was accessible to all. A small consultation room was available to support private conversations with people. This room was accessible off the public area with access monitored by team members working on the medicine counter.

Staff-only areas of the premises were clearly separated from the public space by the medicine counter. Space in the dispensary was limited for the volume of items dispensed. But workflow was effective and team members used the available space well. Stairs to the back of the dispensary led to a storeroom. The storeroom provided additional space for holding dispensary sundries, archiving, medicine waste and bags of confidential waste waiting to be collected.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from licensed sources. And it generally stores its medicines safely and securely. It makes appropriate checks to ensure medicines are safe to supply. Pharmacy team members work effectively together when providing the pharmacy's services. They provide relevant information to support people in taking their medicines safely.

Inspector's evidence

People accessed the pharmacy through a heavy door at street level from the onsite carpark. Team members working on the medicine counter explained they were vigilant in assisting people with access by holding the door open for them. The pharmacy advertised its opening times and details of its services for people to see. Team members had appropriate knowledge of other local pharmacies and healthcare services. They knew how to signpost people to these services in the event the pharmacy was unable to provide a service or supply a medicine. The team was planning to start the seasonal flu vaccination service the week after the inspection. It was taking bookings for the service and was preparing equipment and paperwork to support the smooth running of the service. Paperwork included the NHS service specification and national protocol which clearly listed team members roles and responsibilities when delivering the service using this model. Team members were observed requesting people attend their appointment with their NHS numbers, if possible, to support the efficiency of the service.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. Team members were observed asking appropriate questions when responding to a request for a P medicine. A team member confidently discussed the checks they made when managing requests for higher-risk P medicines that may be subject to abuse, misuse, and overuse. The team was vigilant about monitoring requests for these medicines and referred repeat requests to the RP. The pharmacy identified some higher-risk medicines during the dispensing process. This prompted additional safety checks when supplying these medicines. Pharmacists provided verbal counselling when supplying medicines requiring ongoing monitoring. But interventions carried out in this way were not generally recorded on people's medication records (PMRs) to support continual care. Pharmacy team members had some awareness of the requirements of the valproate Pregnancy Prevention Programme (PPP), including the need to refer people in the at-risk group to the RP for counselling. A discussion with the RP highlighted the specific counselling requirements of the PPP when supplying valproate to people within the at-risk group.

The pharmacy had effective systems for managing owed medicines and medicines it delivered to people's homes. The majority of the pharmacy's workload was repeat prescriptions. It managed this well by dispensing prescriptions in date order. Appropriate checks were made to ensure prescriptions for acute medicines such as antibiotics were prioritised for dispensing. A range of audit trails supported team members in answering queries they may receive about the pharmacy's dispensing services. This included team members taking ownership of their work by signing their initials within the 'dispensed by' and 'checked by' boxes on medicine labels. The team kept each person's prescription separate throughout the dispensing process by using baskets.

The pharmacy obtained its medicines from licensed wholesalers, and it stored them tidily and mostly

within their original packaging. A few loose blisters were found on the dispensary shelves; appropriate action was taken to dispose of those without batch numbers and expiry dates clearly visible. Team members explained they recorded date checking activities. But the date checking record could not be found during the inspection. A random check of dispensary stock found no out-of-date medicines. The pharmacy kept CDs securely, with date-expired and patient-returned CDs appropriately labelled and separated. The pharmacy's medicine fridges were an appropriate size for the medicines they held. The team reported that one fridge had been delivered within the last week to support stock holding arrangements for flu vaccinations. The team had yet to record the operating temperature range of this fridge. Other fridge temperature records showed that the temperatures had stayed within two and eight degrees Celsius. And a record for the new fridge was started during the inspection. The temperature of the fridge was noted to be within the acceptable range. The pharmacy had appropriate medical waste receptacles to support the safe disposal of medicine waste. It received medicine alerts through a secure messaging channel and by email and it took timely action in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to the equipment they need to provide the pharmacy's services safely. And they use this equipment with care to protect people's confidentiality.

Inspector's evidence

Pharmacy team members had access to written reference resources. They could also access the internet to help them look up information. They had reported concerns about the speed of the internet connection. The RP explained they received good mobile signal in the area, including 5G and would sometimes use mobile devices when accessing online reference resources. Team members used password protected computers and NHS smartcards when accessing people's medication records. The layout of the pharmacy suitably protected information on computer monitors from unauthorised view. The team stored bags of assembled medicines in a retrieval system. This adequately protected details on bag labels and prescription forms.

Pharmacy team members used appropriate counting and measuring equipment when dispensing medicines. This included separate equipment for measuring higher-risk medicines which mitigated any risk of cross contamination when dispensing these medicines. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. For example, the pharmacy's blood pressure monitors were on the list of monitors validated for use by the British and Irish Hypertension Society. Team members reported regular health and safety checks of equipment and facilities taking place. For example, electrical equipment was subject to periodic safety checks.

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.