General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jardines Pharmacy, 1 Concorde Square, Berryfields, Aylesbury, Buckingshamshire, HP18 1AS

Pharmacy reference: 9012357

Type of pharmacy: Community

Date of inspection: 04/09/2024

Pharmacy context

This is a community pharmacy in a local shopping area in a residential area of Aylesbury, Buckinghamshire. The pharmacy dispenses NHS and private prescriptions. Its team members sell over-the-counter (OTC) medicines and provide advice. The pharmacy also offers the Pharmacy First 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 adequately manages the risks associated with its services. Members of the pharmacy team know how to help protect the welfare of vulnerable people. And they protect people's confidential information suitably. But team members could do more to make their internal processes safer by routinely maintaining relevant audit trails. They may also be missing opportunities to spot patterns and prevent similar mistakes reoccurring if they don't have the necessary records to help demonstrate this.

Inspector's evidence

This is a new pharmacy. The pharmacy had the required range of documented standard operating procedures (SOPs) in place. They provided guidance for the team to complete tasks appropriately. The SOPs had been read and signed by the staff. Team members understood their roles and responsibilities and they knew which activities could take place in the absence of the responsible pharmacist (RP). The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

The pharmacy was clean. There were designated sections for staff to work in and store prescriptions. This included a separate area for the pharmacist to accuracy check prescriptions from, as well dedicated areas for storing assembled and owed medicines. Staff used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. However, the pharmacy's workspaces were not as clear of clutter as they could have been, some of this was observed to be work in progress. After dispensing labels had been generated, there was a facility on them which helped identify who had been involved in the dispensing process. However, team members were not routinely using this as an audit trail.

The pharmacist's process to manage dispensing errors which reached people was suitable. Staff said that there had been no near miss mistakes made since the pharmacy opened but the team could not locate the near miss record to help demonstrate that the pharmacy had appropriate systems in place to record and review this information.

The pharmacy ensured people's confidential information was kept secure and displayed details about how it did this. Staff explained that they usually dispensed prescriptions in the middle of the dispensary. Team members used their own individual NHS smart cards to access electronic prescriptions and the pharmacy's computer systems were password protected. Confidential waste was disposed of suitably. The pharmacist and staff were also trained to safeguard the welfare of vulnerable people. They had access to suitable contact details for relevant agencies in the event of a concern.

The pharmacy's records were mostly kept in accordance with statutory and best practice requirements. This included a sample of registers seen for controlled drugs (CDs), and records of emergency supplies. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. However, there were currently two RP records being maintained, a paper and electronic version. The paper record consisted of loose sheets, which could be lost, or details replaced. There were also odd entries seen where Tippex had been used and occasional missing entries (such as no entry on 31 August 2024). In addition, within the electronic register for supplies made against private prescriptions, some details of the prescribers were seen to be incomplete, and the

pharmacy had not retained the private prescriptions which had been dispensed. Staff said that they had been inadvertently sent to the company's head office as they were unsure what to do with them. However, this meant that it was not possible to fully verify the details within the records that had been made. It was highlighted to the team that all private prescriptions that have been dispensed within the previous two years should be readily available for inspection.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s team members have a range of qualifications, skills, and experience. And they are knowledgeable about the medicines they sell. But the pharmacy team doesn't have structured ongoing training. This could mean that learning needs are not always identified or addressed.

Inspector's evidence

Staff present during the inspection included a locum pharmacist and a dispensing assistant who was also studying to become a pharmacist at university. There was also another trained, full-time dispenser. The team wore uniforms and was largely up to date with the workload. Staff asked appropriate questions before selling Pharmacy-only medicines (P-medicines). They were aware of medicines which were liable to abuse and managed multiple requests for these medicines suitably. They also referred appropriately. As they were a small team, discussions took place regularly. They were provided with updates by email, through the area manager and newsletters which had been issued by the company. However, the dispensing assistant had spent two summers working or the company, she had not had any performance review and there was currently no structured training in place for the team. Staff said they were not provided with any resources to help with ongoing training.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises provide a suitable environment for people to receive healthcare services. The pharmacy is kept clean and professionally presented. And it has a separate space where confidential conversations or services can take place.

Inspector's evidence

The pharmacy premises were new with modern fixtures and fittings. They included a spacious retail area and dispensary with staff areas at the very rear and a consultation room. The dispensary had enough space to carry out dispensing tasks safely. The consultation room was also clearly signposted, spacious, and appropriate for its intended purpose. The pharmacy was clean and tidy. The premises were bright, suitably ventilated, and professional in appearance. The ambient temperature was suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

People can easily use the pharmacy's services. The pharmacy obtains its medicines from reputable sources and manages them appropriately. And team members routinely identify people who receive higher-risk medicines. But they don't always record details when relevant checks are made with these people. This limits the pharmacy's ability to show that people are provided with appropriate advice when supplying these medicines.

Inspector's evidence

People could enter the pharmacy from the street and the pharmacy's retail area consisted of wide aisles and clear, open space. This assisted people with restricted mobility or using wheelchairs to easily enter and access the pharmacy's services. Details about the pharmacy's opening times were clearly advertised, and the pharmacy had some posters on display to provide information about various health matters. Staff described making reasonable adjustments for some people with different needs if this was required. This included providing people with written details, using representatives, physically assisting, and communicating verbally to people who were visually impaired. The team was also multi-lingual and could use Google Translate to help people whose first language was not English.

The pharmacy's workload was currently and predominantly dispensing prescriptions which were collection-based. After receiving prescriptions electronically and printing them, they were processed in batches before being placed into an alphabetical retrieval system and then assembled. Dispensed medicines requiring refrigeration and CDs were stored within clear bags which helped easily identify the contents upon hand-out.

Staff were aware of the risks associated with valproates. They were aware of people at risk who had been counselled effectively when they received this medicine from the pharmacy. Appropriate literature was also available to provide to people if needed. However, when they placed the dispensing label on these medicines, they did not ensure that the warning labels were visible. This was discussed at the time. The team routinely identified people prescribed other higher-risk medicines, they asked about relevant parameters, such as blood test results, and counselled appropriately, but there were no records kept about this.

The pharmacy's stock was stored in a very organised way. The pharmacy used licensed wholesalers to obtain medicines and medical devices. Medicines were date-checked for expiry regularly; records were kept verifying when this had taken place and short-dated medicines were identified. Liquid medicines, when opened were also marked with the date they had been opened. This helped determine stability when dispensing them in the future. Drug alerts were seen to have been received by email and said to have been actioned appropriately by another member of staff. 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 an appropriate range of equipment available to provide its services. And it keeps its equipment sufficiently clean.

Inspector's evidence

The pharmacy team had access to current reference sources, they could use standardised conical measures to measure liquid medicines and they had the necessary equipment for counting tablets. The dispensary sink for reconstituting medicines was clean and the pharmacy had hot and cold running water available.

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.