General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Badham Pharmacy Ltd, 118 Swindon Road, CHELTENHAM, Gloucestershire, GL50 4BJ

Pharmacy reference: 1116985

Type of pharmacy: Community

Date of inspection: 14/08/2023

Pharmacy context

This is a community pharmacy close to a Health Centre in Cheltenham, Gloucestershire. The pharmacy is open for 100 hours every week. It dispenses NHS and private prescriptions. The pharmacy offers a few services such as the New Medicine Service (NMS), local deliveries, and free blood pressure measurements. It also supplies many people with their medicines inside multi-compartment compliance packs if they find it difficult to take them.

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 identifies and manages the risks associated with its services in a satisfactory way. It has the insurance it needs to protect people if things go wrong. Members of the pharmacy team understand their role in protecting the welfare of vulnerable people. And they largely deal with their mistakes responsibly. But they are not always recording and reviewing all the necessary details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. The team could also do more to protect people's confidential information appropriately and keep all the pharmacy's records up to date.

Inspector's evidence

The pharmacy was much improved since the last inspection. The size of the premises was still limited in comparison to the workload and team members were running a day or so behind with the workload. However, there were more staff available to manage the workload, the premises were clean, the dispensary was clear of clutter and previous issues had largely been rectified.

The pharmacy had a range of documented standard operating procedures (SOPs) to provide its team with guidance on how to complete tasks appropriately. There was evidence that staff had read and signed them, this was work in progress for newer members of the team. Team members were clear on their roles and responsibility. They also knew which activities could take place in the absence of the responsible pharmacist (RP). Inexperienced staff were still learning about this but were appropriately supervised. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

The pharmacy had some systems in place to identify and manage risks associated with its services. People were served promptly. Team members concentrated on one task at a time and worked in designated areas. They ensured people's details were fully verified before handing out prescriptions which had been assembled. The RP described handling dispensing incidents which reached people in a suitable way, the relevant details were recorded and investigated appropriately. Errors that occurred during the dispensing process (near miss mistakes) were recorded but there were gaps seen within them. There was also no evidence that the details were regularly collated and reviewed to help identify any trends or patterns. Staff said that they had a meeting to discuss mistakes and raise awareness but there was no documented information to verify this.

The RP had been trained to level three to safeguard the welfare of vulnerable people. Members of the team could also recognise signs of concern; they had been trained appropriately. However, the pharmacy had no contact details readily available for the local safeguarding agencies, this could lead to a delay in the event of a concern. The pharmacy also had processes in place to ensure people's confidential information was protected. There was no confidential material visible. Bagged items waiting collection could not be viewed by people using the pharmacy and the team separated confidential waste from normal waste before this was disposed of securely via an authorised carrier. The pharmacy's computer systems were password protected. However, only a few members of the team held their own NHS smart cards to access electronic prescriptions. One NHS smart card was seen to be in use when this member of staff was not present at the pharmacy and team members knew their password. This limited the pharmacy's ability to control access to people's confidential information. This

was removed and the locum pharmacist's used when highlighted by the inspector.

The pharmacy had current professional indemnity insurance. A sample of registers seen for controlled drugs (CDs) and records of supplies of unlicensed medicines as well as emergency supplies had been maintained in accordance with legal requirements. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. The RP record was mostly complete, but odd details of when the pharmacist's responsibility had ceased were missing. For supplies made against private prescriptions, staff confirmed that they were behind with maintaining the records. Within the electronic register for supplies made against private prescriptions, some details of the prescribers were missing or were seen to be incomplete. This could make it harder for the pharmacy to find these details in the event of a future query.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload appropriately. And the pharmacy provides its services using a team with various levels of experience. But they are not provided with many resources to complete their ongoing training. This could affect how well their skills and knowledge are kept up to date.

Inspector's evidence

During the inspection, the pharmacy team consisted of a locum pharmacist, two trained dispensing assistants, one of whom was a locum and a relatively new medicines counter assistant (MCA). The staffing profile also had two more new starters and locum dispensers were extensively used as contingency. One of the directors who was a pharmacy technician arrived shortly after the inspection started to provide lunch cover. A new pharmacist manager had also been recruited. Team members wore name badges and uniforms. Although multi-compartment compliance packs were being prepared a day before they were due, the pharmacy had enough staff now to support the workload.

Trained staff supervised the MCA. This member of staff knew to ask some relevant questions before selling medicines, always referred to the pharmacist appropriately and was aware of medicines which could be abused. As they were a small team, meetings and discussions took place amongst themselves. Staff performance appeared to be work in progress by the company’s head office. Some members of the team were enrolled onto appropriate accredited training in line with their role(s). Other members of the team, however, were not provided with any resources for ongoing training.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an adequate environment to deliver services from. The pharmacy is secure. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy premises consisted of a small retail space and dispensary, a consultation room, an upstairs section which had staff facilities and was also used to prepare compliance packs. The latter was spacious. The pharmacy was suitably bright, appropriately ventilated and the ambient temperature was suitable to store medicines. The premises were clean and tidy. And secured appropriately to prevent unauthorised access. Bench space in the dispensary on the ground floor was limited in terms of the pharmacy's volume of workload but they were kept clear of clutter. There was a designated area for the pharmacist to accuracy-check prescriptions in this dispensary but only an exceedingly small and limited section for staff to use when dispensing prescriptions. Trained staff explained that they were still unable to physically go upstairs to use the larger space just yet because of the need to help supervise newer members of the team. The pharmacy's consultation room provided a secluded area to hold conversation but was accessed via a small single step from the waiting area. This was not easily accessible to people using wheelchairs due to the narrow size and space of the room. The room had a desk, seats, and relevant equipment. It was not locked and led to the upstairs section, but it was signposted clearly.

Principle 4 - Services ✔ Standards met

Summary findings

People with diverse needs can easily access the pharmacy's services. The pharmacy obtains its medicines from reputable sources and stores as well as manages its medicines appropriately. Members of the pharmacy team suitably dispose of people's unwanted medicines. And ensure recalled items are dealt with appropriately. But the pharmacy does not always identify people who receive higher-risk medicines and make the relevant checks. This limits its ability to show that people are provided with appropriate advice when supplying these medicines. And it does not always assess all the risks involved with some of its working practices when it provides some services.

Inspector's evidence

People could enter the pharmacy through the front door which was accessible from the street via a slight ramp and the retail space, although small, was made up of clear, open space. This meant that people with restricted mobility or using wheelchairs could easily enter the pharmacy. Team members were multilingual. This assisted people whose first language was not English. Staff described making reasonable adjustments for some people with different needs if this was required. This included providing people with written details or communicating verbally to people who were visually impaired. One member of staff was also learning sign language. There were a few seats for people if they wanted to wait for their prescription. The pharmacy's opening hours were on display and the pharmacy was open for long hours. This provided a convenient service for people if they needed to access the service outside of normal hours.

The workflow involved prescriptions being prepared in one area, the RP checked medicines for accuracy from another section and a designated space was used to assemble compliance packs. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer. Once staff generated the dispensing labels, however, there was no facility on them to help identify who had been involved in the dispensing process and no verifiable audit trail available. This was not the case at the last inspection and one of the directors of the company confirmed that the system had been updated recently.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. There was evidence that the staff checked medicines for expiry regularly, short-dated medicines were identified and there were no date-expired medicines seen. CDs were stored securely and medicines requiring refrigeration were stored in a suitable way. Fridge temperatures were checked daily. Records verifying this and that the temperature had remained within the required range had been appropriately completed. Medicines returned for disposal, were accepted by staff, and stored within designated containers. This included people who brought sharps back for disposal. Staff explained the action the pharmacy took in response to drug alerts and relevant records were kept verifying this.

Dispensing staff were aware of the additional guidance when supplying sodium valproate and the associated Pregnancy Prevention Programme (PPP). Staff were unclear however, whether the pharmacy had identified people at risk, who had been supplied this medicine. People prescribed other higher-risk medicines or medicines that required ongoing monitoring were also not routinely identified. The team did not ask relevant questions or details about their treatment nor was this information regularly recorded.

People's medicines were delivered to them, and the team kept specific records about this service. This helped verify and trace who had received their medicines in this way. CDs and fridge lines were highlighted. Failed deliveries were brought back to the pharmacy and notes were left to inform people about the attempt made. However, medicines were put through people's letterboxes after obtaining their consent. However, there were no documented details to help show that the pharmacy team had considered all the risks involved with this.

The pharmacy provided people who lived in their own homes with their medicines inside compliance packs. This was in conjunction with the person's GP and once a need for this had been identified. Staff prepared compliance packs in a separate location and maintained individual records for people who received their medicines in this way. Any queries were checked with the prescriber and the records were updated accordingly. Descriptions of the medicines inside the packs were always provided and patient information leaflets (PILs) were routinely supplied. All medicines were removed from their packaging before being placed inside the compliance packs.

However, several compliance packs had been left unsealed overnight and for the past week at the point of inspection. They were placed inside baskets and had elastic bands around them which helped minimise some of the risks involved with this practice. Staff explained that this was because they were waiting for owed medicines so that they could easily add them in afterwards. The pharmacy team was advised to change their internal processes so that this did not happen in future. There were also some potential concerns noted with the pharmacy's practice of placing sodium valproate inside compliance packs due to issues with its stability. There had been no risk assessments conducted about this or any details recorded to help justify this situation. This was discussed at the time.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has an appropriate range of equipment and facilities to provide its services. Its equipment is kept suitably clean.

Inspector's evidence

The pharmacy team had access to reference sources and relevant equipment. This included counting triangles, standardised, conical measures, fridges, legally compliant CD cabinets and a clean sink that was used to reconstitute medicines. Hot and cold running water was available as well as hand wash. The pharmacy had its computer terminals positioned in a way and location that prevented unauthorised access. The pharmacy used an automated software system (Methasoft) to dispense methadone for people. This was calibrated and cleaned daily, and records were maintained to help verify.

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.