General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Badham Pharmacy Ltd, 84 St. Georges Place, CHELTENHAM, Gloucestershire, GL50 3QD

Pharmacy reference: 1122307

Type of pharmacy: Community

Date of inspection: 08/08/2019

Pharmacy context

This is a community pharmacy in the centre of the town of Cheltenham. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. They supply medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines. They also supply medicines to the residents of eight local care homes.

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	2.4	Good practice	The staff are encouraged to keep their skills up to date and they do this in work time. The team members who are training are well supported. The pharmacist conducts comprehensive performance reviews, particularly of new members, to identify any gaps in their knowledge.
		2.5	Good practice	The team works well together and they feel comfortable about providing feedback to the pharmacist to improve services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy team intervene if they are worried that people may not be using their medicines as prescribed by their doctors. The pharmacist proactively consults other healthcare professionals and takes part in pilot schemes to provide safer services to people.
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 safe and effective. The downstairs working area is small but the team members manage this risk well. They learn from mistakes to prevent them from happening again. The pharmacy keeps the up-to-date records that it must by law. The team members keep people's private information safe and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy staff identified and managed risks. The downstairs dispensary was extremely limited in size and the staff endeavoured to keep the benches as clear as possible in order to reduce the risk of errors. There were small labelling, assembly and checking areas. Upstairs, there were two separate dispensaries, one for multi-compartment compliance aids and one for the care homes. These were both tidy and organised.

Any dispensing errors or incidents were recorded, reviewed and appropriately managed. There had been a recent error involving an Ellipta inhaler. The accuracy checking technician had been interrupted whilst checking this because it was busy. The staff now endeavoured to finish one task before taking on another one. Near misses were recorded but some had insufficient information to allow useful analysis, such as, a recent form error with co-careldopa. The near miss log was reviewed monthly and trends were identified, such as, in July 2019 where there had been several quantity errors. Because of this, the staff were circling the quantity on the label and on the prescription to demonstrate that this had been thoroughly checked.

There was a clear audit trail of the dispensing process and all the 'dispensed by' and 'checked by' boxes on the labels examined had been initialled. Any prescriptions checked by the accuracy checking technician had been previously clinically checked by the pharmacist and there was an audit trail demonstrating this.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were reviewed every two years of sooner, if necessary, by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. There was no displayed sales protocol but all the staff seen were trained dispensers. A trainee technician said that she would refer any requests for medicine sales that she was uncertain of to the pharmacist. The staff were aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) or 'general sales list' (GSL) switches such as, Viagra Connect and fluconazole and said that requests for these were referred to the pharmacist. Multiple sales requests for codeine-containing products would also be referred to her.

The team members were clear about the complaints procedure and reported that feedback on all concerns was actively encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, 100% of customers who completed the questionnaire were largely satisfied with the service they received from the pharmacy. However, 8% of customers commented on the time it took to have their prescriptions to be dispensed. The staff explained that this was because the pharmacist was often upstairs checking the compliance aid or care home prescriptions. The pharmacy only had an accuracy checking technician on two days a week.

Public liability and indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 30 November 2019 was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

There was an information governance procedure and the staff had also recently completed training on the new data protection regulations. The computers, which were largely not visible to the customers, were password protected (but see further under principle 3). Confidential information was stored securely. Confidential waste paper information was shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had completed Virtual Outcomes training on this. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough staff to manage its workload safely. But, a recent full-time team member has only been replaced with a part-time, temporary, inexperienced member. This may cause issues in the future. The staff are encouraged to keep their skills up to date and they do this in work time. The pharmacist also encourages them to undertake further learning. The team members who are training are well supported. The team works well together and they feel comfortable about providing feedback to the pharmacist to improve services. The pharmacist conducts comprehensive performance reviews, particularly of new members, to identify any gaps in their knowledge. And, she keeps notes of the discussions in the monthly staff meetings.

Inspector's evidence

The pharmacy was in the centre of Cheltenham. They dispensed approximately 5,500 NHS prescription items each month with the majority of these being repeats. 82 patients receiving care in their own homes and 250 care home patients (nursing and residential) received their medicines in multi-compartment compliance aids. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist (the manager), one full-time NVQ2 qualified dispenser and one part-time NVQ2 qualified dispenser, also a NVQ3 trainee technician. The pharmacist reported that four weeks ago, a full-time dispenser had been re-located. The services of a pharmacy student had been secured, but only part-time. And, the pharmacy student will be returning to university in the autumn. An accuracy checking technician (ACT) worked at the pharmacy but for only two days each week. There were also two part-time drivers.

The part-time trainee technician was flexible and could cover some unplanned absences. Planned leave was booked well in advance and only one member of staff could be off at one time. Planned holidays were covered by the company's head office or by locum staff.

The staff were well qualified and clearly worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal where any learning needs or gaps in knowledge could be identified. A dispenser had recently raised that she would like to do the smoking cessation course. A training day for this had been arranged for September 2019. Any new staff had a monthly review for the first six months, then every three months in the first year of employment. The manager kept comprehensive notes about these.

The staff were encouraged with learning and development and completed virtual Outcomes e-Learning. The manager also proactively provided that staff with training, such as, recently on the Falsified Medicines Directive (FMD). The staff reported that they spent about 30 minutes each month of protected time learning. Staff enrolled on accredited courses, such as the NVQ3 technician's course, were allocated a further two hours each week for learning. All the staff reported that they were well supported to learn from errors. The pharmacist said that all learning was documented on her continuing professional development (CPD) records.

The staff knew how to raise a concern and reported that this was encouraged and acted on. The trainee technician had recently raised an issue with compliance aid folders. Because of this, the pharmacy had

changed their procedures which had resulted in better procedures. There were monthly staff meetings and the manager kept minutes of the meetings. The staff all said that they were able to raise anything with the manager and that they were well supported by her.

The pharmacist reported that she was set overall targets, such as 400 annual Medicines Use Reviews (MURs). She said that she only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean. Some of the work areas are small but they are tidy and organised. The consultation room is signposted so it is clear to people that there is somewhere private for them to talk. But, the room is small and it may be difficult to place a person in the recovery position on the floor, if necessary, following an untoward reaction to a flu vaccination.

Inspector's evidence

The main dispensary was limited in size but the staff did their best to manage the space. The upstairs dispensing areas were spacious and organised. The premises were clean and well maintained.

The consultation room was small and so it may be difficult to place a patient in the recovery position on the floor if necessary. The pharmacy did offer a flu vaccination service. The room had a computer and a small sink. The design of the room meant that it was difficult to obscure the computer screen from customers. The pharmacist was aware of this and did her best to turn the screen away from view. Conversations in the consultation room could not be overheard. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

The temperature in the pharmacy was only just below 25 degrees Celsius. It was not a particularly warm day on the day of the inspection. There was good lighting throughout. All items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

Most people can access the services that the pharmacy offers. But, some people with specific mobility needs may have difficulty entering the pharmacy and accessing the consultation room. The services at the pharmacy are effectively managed to make sure that they are provided safely. The pharmacy team make sure that people have the information that they need to use their medicines safely and effectively. They intervene if they are worried that people may not be using their medicines as prescribed by their doctors. The pharmacist proactively consults other healthcare professionals and takes part in pilot schemes to provide safer services to people. The team make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was no independent wheelchair access to the pharmacy and the consultation room because of a small step up. In addition, because of the limited space at the pharmacy, the empty wholesale order crates were stored close to the front door which further impeded access. And, there was no bell on the front door to alert staff to any wheelchair users who may need assistance entering the pharmacy. There was access to Google translate on the pharmacy computers for use by non-English speakers. The pharmacy had printed large labels for sight-impaired patients in the past. Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), the New Medicine Service (NMS), minor ailment scheme, urgent repeat medicine scheme and flu vaccinations. The latter was also provided under a private agreement. No substance misuse patients had their medicines supervised. The services were well displayed and the staff were aware of the services offered. The pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis.

The majority of the business at the pharmacy was the assembly of medicines into multi-compartment compliance aids. 82 patients receiving care in their own homes and 250 care home patients (nursing and residential) received their medicines in compliance aids. Two separate rooms upstairs were used for the assembly of these. The compliance aids for patients in their own homes were assembled on a four week rolling basis and evenly distributed throughout the week to manage the workload. There was a clear colour-coded ordering system and a clear dispensing progress log. There were dedicated folders for these patients where all the relevant information, such as, hospital discharge sheets and changes in dose were kept. Changes were recorded in clear, concise, chronological order. These were referred to at the checking stage. Any prescriptions checked by the ACT had been previously clinically checked by the pharmacist. The assembled compliance aids were stored tidily and there was a dedicated shelf for any patients who were in hospital.

The pharmacy also provided services to eight homes. The homes ordered their own prescriptions. The pharmacy checked the prescriptions against what had been ordered. The homes sent the pharmacy monthly up-to-date racking lists and any patients with known allergies. The surgeries sent the pharmacy written confirmation of any changes or other issues. Communication diaries were used for each home. The pharmacist provided training to the homes, usually in her own time. She also arranged meetings with the staff. She conducted clinical audits and did mock Care Quality Commission (CQC) audits.

Procedures were in place to ensure that all compliance aid patients receiving high-risk drugs were having the required blood tests. The pharmacist had had a meeting with the reception manager and the

lead pharmacist of a local surgery and was taking part in a high-risk drug monitoring scheme. Any high-risk drugs that were delivered to patients had to be specially signed for. All the staff were aware of the new sodium valproate guidance. The pharmacy had identified one patient in the at-risk group who was prescribed this, but, wanted to start a family and so was not taking any contraceptive precautionary measures. The pharmacist contacted her doctor and her prescription was changed from sodium valproate to levetiracetam.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. Interventions were seen to be recorded on the patient's prescription medication record. Green 'see the pharmacist' stickers were used. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded. Guidance leaflets were given to all patients prescribed high-risk drugs. The pharmacist also counselled patients prescribed amongst others, antibiotics, new drugs, oral steroids and any changes. CDs and insulin were checked with the patient on hand-out.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Potential non-adherence or other issues were identified at labelling, ordering and hand-out. Any patients giving rise to concerns were targeted for counselling. The pharmacist reported that she frequently identified during MURs that patients were not having routine reviews and blood tests at their surgeries. She contacted the surgeries to arrange these.

Medicines and medical devices were obtained from AAH, Alliance Healthcare and Badham's Warehouse. Specials were obtained from the Specials Laboratory. Invoices for all these suppliers were available. Some items obtained from the company's warehouse, such as, thiamine 100mg were unlicenced. The pharmacist said that she would discuss this issue with the superintendent pharmacist. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no patient-returned or out-of-date CDs. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for waste medicines and used. There was a list of cytostatic and cytotoxic substances and a designated waste bin for these substances.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. In addition, a separate clear, concise audit sheet was completed. The pharmacy had received an alert on 13 June 2019 about paracetamol. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services its provides.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10ml to 100ml). There were tablet-counting triangles which were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2018/2019 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and mainly not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential information was shredded. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.