

Registered pharmacy inspection report

Pharmacy Name: Badham Pharmacy Ltd, 94 High Street,
TEWKESBURY, Gloucestershire, GL20 5JZ

Pharmacy reference: 1126148

Type of pharmacy: Community

Date of inspection: 19/09/2024

Pharmacy context

This is a community pharmacy in the centre of the market town of Tewkesbury, Gloucestershire. The pharmacy dispenses NHS and private prescriptions. It's team members sell over-the-counter medicines and provide advice. And the pharmacy offers the Pharmacy First Service, the New Medicine Service (NMS), as well as seasonal flu vaccinations.

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	1.8	Good practice	The pharmacy's team members actively ensure the welfare of vulnerable people. They can demonstrate identifying relevant concerns and taking appropriate action in response. The pharmacy has processes in place to assist with this and team members are suitably trained.
2. Staff	Standards met	2.2	Good practice	The pharmacy's team members have the appropriate skills, qualifications and competence for their roles and the tasks they carry out or they are undertaking accredited training for this.
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 operates safely. The team actively protects the welfare of vulnerable people and ensures that people's confidential information is kept secure. And the pharmacy maintains most of its records in accordance with the law. Members of the pharmacy team deal with their mistakes responsibly. But they are 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.

Inspector's evidence

This was a well-run pharmacy. The pharmacy team had access to a range of current standard operating procedures (SOPs). They provided guidance for the team to carry out tasks correctly and had been signed by the staff. Team members knew their roles and responsibilities and they were observed to work independently of the responsible pharmacist (RP) in separate areas of the pharmacy. Newer members of staff were appropriately supervised, they were in the process of reading the SOPs and the company's induction book. They were also knowledgeable about safeguarding the welfare of vulnerable people (see below) and data protection.

Team members described paying attention when dispensing and during the accuracy checking process. A three-way check of the details on the prescription, generated dispensing label and medicine took place before medicines were passed to the pharmacist for the final accuracy-check. Staff also concentrated on one task at a time and worked in designated areas. Multi-compartment compliance packs were assembled in a separate area which was to one side of the main dispensary activity. This helped minimise distractions. Once prescriptions were assembled, staff used stickers to highlight certain situations (see Principle 4). This included identifying people with similar names which helped prevent hand-out errors.

The pharmacy had a suitable complaints and incident management process; the RP's process to manage dispensing errors which reached people was suitable and in line with these procedures. Details about the pharmacy's complaints process were also on display in the retail area. Staff recorded mistakes that occurred during the dispensing process (near miss mistakes). Medicines which had similar names, packaging, looked-alike or sounded-alike (LASA's) were separated and the team had clearly highlighted them on the dispensary shelves. This helped them to minimise mistakes. However, there were some gaps seen in the near miss record and the details were reviewed informally with no information seen to be recorded. This was said to be work in progress but could make it harder to spot patterns and trends.

The pharmacy displayed details in the retail area explaining its privacy policy. Confidential material was stored and disposed of appropriately and there were no sensitive details that could be seen from the retail space. Computer systems were password protected and staff used their own NHS smart cards to access electronic prescriptions. The pharmacist had been trained to level three and all staff were trained to safeguard the welfare of vulnerable people. This included newer members of the team. They recognised signs of concern, knew who to refer to and described concerns seen as well as how they had responded. Formal safeguarding referrals had also been made and contact details for the local safeguarding agencies were easily accessible.

The pharmacy displayed details about the pharmacist responsible for the pharmacy's activities. It also

had the appropriate indemnity insurance in place. The pharmacy's records were mostly compliant with relevant requirements. This included a sample of registers seen for controlled drugs (CDs). On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy were complete as were records verifying that fridge temperatures had remained within the required range. However, incorrect details about prescribers had been documented within the electronic private prescription register which could make it harder for the pharmacy to find these details in the event of a future query. Unclear abbreviations were also seen to record the nature of the emergency when a supply of a prescription-only medicine was made, in an emergency without a prescription. This could make it harder for the pharmacy to justify the supplies made. This was discussed at the time.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Members of the pharmacy team have a range of skills and experience. They understand their roles and responsibilities well. Team members have access to some resources so that they can complete ongoing training. But this is not always delivered in a structured way, which may make it harder for them to keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy team at the inspection consisted of a locum pharmacist, and five dispensing assistants, most of whom were trained appropriately for this role and included the pharmacy manager. The newest member of the team was enrolled onto accredited training for her role and was working on the medicines counter at the point of inspection. The team's certificates of qualifications obtained were seen and their competence was demonstrated. The pharmacy had enough staff to support the workload and the team was up to date with this. A positive rapport between the team was observed. Staff wore uniforms and name badges. Many of them were long-standing as well as experienced members of the team. The new member of staff asked relevant questions before selling medicines, she was aware of medicines which could be abused or had legal restrictions and sales of these medicines were monitored.

Staff knew when to refer to the pharmacist appropriately. Their performance reviews occurred annually, and discussions took place regularly. Team members communicated verbally, they had regular huddles or meetings where updates were provided, and they received appropriate communication from the company's head office via email. The inspector was aware that the company's superintendent pharmacist was due to implement training resources for people who worked for them. This had not yet transpired but staff currently had access to some online resources for ongoing training. This helped members of the pharmacy team to keep their knowledge up to date, but the training was not currently delivered or monitored in a structured way.

Principle 3 - Premises ✓ Standards met

Summary findings

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

Inspector's evidence

The pharmacy's premises were presented professionally. The pharmacy was clean and tidy, and the retail area was spacious. The lighting and ambient temperature within the pharmacy was appropriate for storing medicines and safe working. The premises were also secure from unauthorised access. The dispensary was smaller than the retail area with an adequate amount of bench space for staff to carry out dispensing tasks safely. Dispensing benches were kept clear of clutter. There was a clean sink in the dispensary for preparing medicines which had hot and cold running water. The pharmacy had a separate consultation room in the shop area which was used for private conversations and providing services. It was of an appropriate size, clearly signposted and accessible for people using wheelchairs. Conversations at a normal level of volume could take place inside without being overheard.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are delivered safely. The pharmacy sources its medicines from reputable suppliers. It stores and manages its medicines well. The pharmacy has processes in place to ensure medicines are suitably dispensed and delivered. And team members routinely identify people who receive higher-risk medicines. But they don't always record any relevant information. This makes it difficult for them to show that people are provided with appropriate advice when they supply these medicines.

Inspector's evidence

The pharmacy's opening times and some of its services were clearly advertised. The pharmacy had information and leaflets on display to promote health. People could enter the pharmacy through the front door which was powered and step-free. The retail area consisted of clear, open space and wide aisles. This helped people with restricted mobility or using wheelchairs to easily access the pharmacy's services. Team members explained that they assisted people with different needs. A hearing aid loop was available for people who struggled to hear easily, and written communication was also used if required. There were two seats available for people who wanted to wait for their prescriptions and as the pharmacy was on the main High Street, plenty of timed car parking spaces were available outside and within the vicinity.

The workflow involved prescriptions being prepared by staff in one area before the pharmacist checked medicines for accuracy from another section. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. The baskets were also colour coded which helped identify priority. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process. Once prescriptions had been assembled, checked for accuracy, and bagged, they were stored in a separate section and drawers. Dispensed CDs and temperature-sensitive medicines were stored within clear bags. This helped to easily identify the contents upon hand-out. Staff used stickers to identify certain medicines or specific situations. This included fridge lines, CDs, prescriptions for children, if pharmacist intervention was required and for prescriptions with higher-risk medicines such as methotrexate, warfarin, and lithium. Staff were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). They ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them and had identified people in the at-risk group who had been supplied this medicine. However, whilst the team routinely identified prescriptions for people had been prescribed higher-risk medicines and asked about relevant parameters, such as blood test results for people prescribed these medicines, they did not record this information.

The pharmacy supplied medicines inside compliance packs to many people who lived in their own homes, after this was considered necessary and an assessment had taken place. This helped people to manage their medicines more effectively. The team ordered prescriptions on behalf of people. They identified any changes that may have been made, maintained individual records to reflect this and queried details if required. The compliance packs were sealed as soon as they had been prepared. All medicines were de-blistered into the compliance packs. Descriptions of the medicines inside the packs were provided and patient information leaflets (PILs) were routinely supplied.

People's medicines were delivered to them, and the team made records about this service. However, at the point of inspection, the records were not being retained for a suitable period. This limited the team's ability to verify and trace who had received their medicines in this way. This situation was discussed at the time and the pharmacy's process was subsequently amended. CDs and fridge lines were highlighted. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended.

The pharmacy used licensed wholesalers to obtain medicines and medical devices; its medicines were stored in an organised way and highlighted various kinds of medicines. The team checked medicines for expiry regularly and kept records of when this had taken place. Short-dated medicines were routinely identified, there were no medicines seen which were past their expiry date. Liquid medicines, when opened were marked with the date they were opened. This helped to determine stability when dispensing them in the future. CDs were stored securely and the keys to the cabinet were maintained in a way which prevented unauthorised access. Fridge temperatures were checked daily. Records verifying this and that the temperature had remained within the required range had been appropriately completed. Out-of-date and other waste medicines were separated before being collected by licensed waste collectors. Medicines which were returned to the pharmacy by people for disposal, were accepted by staff, and stored within designated containers in a specific, designated area. This included sharps provided they were within sealed bins. Drug alerts were received electronically. Staff explained the action the pharmacy took in response and relevant records were kept verifying this.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. Its equipment is suitably clean. And team members use them appropriately to keep people's confidential information safe.

Inspector's evidence

The pharmacy's equipment was suitable and kept clean. This included standardised conical measures for liquid medicines, triangle tablet and capsule counters. The pharmacy had an appropriately operating pharmacy fridge, legally compliant CD cabinets and access to current reference sources. Staff had access to lockers to store their personal belongings. Portable telephones helped conversations to take place in private if required. The pharmacy's computer terminals were password protected and their screens faced away from people using the pharmacy. This helped prevent unauthorised access.

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.