General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Badham Pharmacy Ltd, Unit 2, The Village Square, Victory Field, Upper Rissington, Cheltenham, GL54 2QB

Pharmacy reference: 9010574

Type of pharmacy: Community

Date of inspection: 29/04/2019

Pharmacy context

The pharmacy is in the small village of Upper Rissington, in the Cotswolds. The village has a lot of new housing but most of the people who use the pharmacy are elderly. The pharmacy dispenses NHS 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. The pharmacy also supplies medicines to care homes, both nursing and residential.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	There is evidence that standard operating procedures are not followed and this is a risk to people's safety. And, most of the services that the pharmacy provides are high-risk and sometimes there are not enough staff to do this safely.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have enough staff to manage their workload safely.
		2.5	Standard not met	There is evidence that insufficient action has been taken when individuals of the pharmacy team have raised legitimate concerns.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	There is evidence that pharmacy services are provided in a way that puts people's safety at risk.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy team has not learned from a potentially serious mistake at another branch to prevent this from happening at their branch. And, most of the services that the pharmacy provides are high-risk and sometimes there are not enough staff to do this safely. Also, the space for doing this work is limited and this increases the risk of errors. The team members encourage people to give feedback. But, they do not know the results of an annual survey and so cannot act on the feedback to improve services. The pharmacy team could also take more care to keep people's information private. The pharmacy is appropriately insured to protect people if things go wrong. The team keep the up-to-date records that they must keep by law.

Inspector's evidence

The pharmacy team identified and managed some risks. But, there had been a potentially serious error at another branch of the company where a multi-compartment compliance aid for someone receiving care at home had been posted through the letterbox of the wrong patient. The patient took the medicines for several days. The standard operating procedures stated that medicines should not be posted through people's letterboxes. The delivery driver at the branch was aware of the error at the other branch but admitted that he did post compliance aids through people's letterboxes. In addition, several delivery sheets were seen not be signed by patients or their carers indicating that they had been safely delivered.

Dispensing errors and incidents at the pharmacy were recorded. The last error was in November 2018 involving Normacol and Normacol Plus and the staff had been made aware of issues with similar names. Few near misses were recorded, three in total for March. All of these were drug errors, such as metformin 1000mg modified release and bicalutamide 50mg. But, it had not been documented what was on the prescription and what was picked and so there was insufficient information to allow any useful analysis. No learning points or actions taken to reduce similar recurrences were recorded. The log was not documented as being reviewed.

A large proportion of the business at the pharmacy was the assembly of medicines into multi-compartment compliance aids. There was a compliance aids for people receiving care at home area, a checking area and a small central bench. The compliance aids for people receiving care at home area had several baskets stored on top of one another which increased the risk of errors. The central bench was used for the preparation of the medicines for the homes, for unpacking the wholesale order and for the general prescriptions. The pharmacy prepared medicines for 100 people receiving care at home using compliance aids and 100 care home patients. On the day of the visit, a Monday, a large amount of work had been left unchecked by the locum working on the previous Saturday. The baskets containing these assembled prescriptions were stored on top of one another on the floor because the central bench was being used to unpack the wholesale order. This increased the likelihood of errors. Also, on the day of the visit, there was just a qualified dispenser and the pharmacist on duty. The pharmacy employed another member of staff, a trainee dispenser, but she only worked part-time. The dispenser seen on the day of the visit had to constantly interrupt her work to take phone calls from the

care homes or to serve customers. This too increased the risk of errors

Coloured baskets only distinguished the different care homes that the pharmacy provided services to and patients with prescriptions for controlled drugs (CDs) and insulin. This meant that is was not easy to prioritise the workload.

Up-to-date and signed standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were reviewed every two years by the superintendent pharmacist.

The roles and responsibilities were set out in the SOPs and the staff seen, just one dispenser and the pharmacist, were clear about their roles. There was no displayed company's sales protocol but the dispenser, a NVQ3 trainee technician, said that she would refer any requests for medicines for young children to the pharmacist. She knew that fluconazole capsules should not be sold to women over 60 for the treatment of vaginal thrush.

The staff seen knew about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. But, they did not know the results of the most recent survey and so could not address any negative feedback to improve services.

Public liability and indemnity insurance provided by the National Pharmacy Association 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 completed training on the new data protection regulations. The computer in the dispensary was not visible to the customers but the design of the consultation room meant that it was difficult to obscure the screen in here. At the time of the visit, the consultation room was unlocked, and, the computer had a patient's details clearly visible. The computers were password protected. Confidential waste paper information was shredded for appropriate disposal. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. No local telephone numbers to escalate any concerns relating to both children and adults were available. The pharmacist gave assurance that these would be obtained. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always have enough staff to manage their workload safely. So, sometimes they fall behind their work schedule. When team members are on holiday, their hours are not always replaced which puts the other team members under pressure. When team members are off sick, some help is provided but they don't always have the experience needed for the services provided by the pharmacy and this too puts the staff under pressure. The staff are encouraged to keep their skills up to date, but they generally do not do this in work time. The team members who are in training are well supported by their immediate manager. But, the staffing arrangements make it difficult for the pharmacy to have a formal training rota so that these members are fully supported to complete their courses within a suitable time scale. The pharmacy team are comfortable about providing feedback to their immediate manager but are not fully supported by the company's head office even after concerns are raised.

Inspector's evidence

The pharmacy was in a small rural village. They dispensed approximately 5,500 NHS prescription items each month with the majority of these being repeats. 100 to 110 patients receiving care at home and 100 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, due to leave the following day and only employed since December 2018, one full-time NVQ3 trainee technician and one part-time NVQ2 trainee dispenser (not seen). At the time of the visit, the staff were behind with their workload. Several baskets of assembled prescriptions, from the previous Saturday (see under principle 1) needed to be checked. The trainee technician said that she did not have enough time to do routine date checking because she was always busy dealing with the homes. The pharmacist had to do this. Several boxes of general non-medicine stock were seen behind the medicine counter waiting to be put away. The staff said that they had insufficient time to do this.

The regular pharmacist was leaving the day following the visit. The dispenser seen did not know if a replacement for him had been found. She was fearful of having different locums each day because of the specialist and time-consuming nature of the services to the care homes.

The part-time trainee dispenser (not seen), had had a week's holiday the week before the visit. No replacement for her had been provided. The staff said that the company's head office approved holiday requests before securing any cover. The trainee technician had been recently off sick for a week. Help was given from other branches, but the staff were not experienced in dealing with care homes and this caused difficulties. The pharmacist said that he had sent emails to the company's head office in January 2019 about staffing. The NVQ2 trainee's hours had been increased by a day, but, both staff members seen said that this was not enough to keep on top of the workload.

There was an annual performance appraisal. The staff were encouraged with learning and development and completed 'Virtual Outcomes' e-Learning but had not been able to do these since October 2018 because of workload pressures. They also completed the learning in their own time, usually during the lunch break. The dispenser seen was a NVQ3 trainee. She said that she was well supported by the

pharmacist but, as already mentioned, he was due to leave the day following the visit. There was no formal training rota and the NVQ3 trainee was not allocated dedicated protected learning time for her course. The pharmacist said that he tried to help her as best as he could, during quiet periods, but the staffing profile did not allow him to a formal training rota. The company provided some other general learning such as a recent evening meeting. The pharmacist said that all learning was documented on his continuing professional development (CPD) records.

The dispenser seen knew how to raise concerns and said that she felt well supported by the pharmacy manager but not always by the company's head office. 'Ad hoc' staff meetings were held. The pharmacist said that he was set overall targets, such as 400 annual Medicines Use Reviews (MURs). He said he received constant email reminders about these targets. The pharmacist added that the pharmacy had few 'walk-in' patients, but he tried to do as many MURs that he could. He only did clinically appropriate reviews.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally looks professional. But, better use of the space could be made to make it more suitable for the services it provides. There is good signposting to the consultation room so it is clear to people that there is somewhere private for them to talk. But, it is difficult for people to sit face-to-face in there and this may hinder some conversations.

Inspector's evidence

The pharmacy generally presented a professional image. But, some of the dispensing benches were cluttered and the floors both in the dispensary and behind the medicine counter were not clear (see under principle 1). Best use of the space in dispensary was not made. There was a small central bench, but space would allow for a much larger unit. The premises were generally clean, but the carpet needed vacuuming. The dispenser said that there was insufficient time to do this. The premises were well maintained.

The consultation room was small, and, the design made it difficult for people to sit face-to-face. Conversations in the consultation room could not be overheard. It would be difficult to obscure the computer screen from people in the consultation room (see under principle 1). The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning and the temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services **Standards not all met**

Summary findings

Most people can access the services the pharmacy offers. But, some people with specific mobility needs may have difficulty entering the pharmacy. The pharmacy team give people who come into the pharmacy the information that they need to use their medicines safely and effectively. But, they do not make sure that vulnerable people living in their own homes and in care homes, who get high-risk medicines, are having the blood tests they need. And, the procedures for the ordering of prescriptions for people in care homes could pose a risk of mistakes. Also, the pharmacy posts medicines through people's letterboxes which poses a risk to their safety. The pharmacy generally gets its medicines from appropriate resources. The pharmacy team make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but no bell on the front door to alert staff to anyone who may need assistance. There was access to Google translate on the pharmacy computers for use by non-English speakers. The pharmacy could print large labels for sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), emergency hormonal contraception (EHC) and seasonal flu vaccinations. The latter was also provided under a private agreement. The pharmacy had no supervised substance misuse patients.

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. He had also completed suitable training for the provision of the free NHS EHC service. No substance misuse patients had their medicines supervised.

Most of the business at the pharmacy was the assembly of medicines into multi-compartment compliance aids. 100 to 110 people receiving care at home and 100 care home patients (nursing and residential) received their medicines in multi-compartment compliance aids. The compiance aids were assembled on a four week rolling basis mainly against weekly prescriptions. Four trays were usually prepared at a time and payment for these was claimed, for all four weeks, at the time of the assembly. This could cause issues if there were any changes or if the medicines were not supplied. The NVQ3 trainee who assembled the trays said that she would change the procedures and only claim for the medicines once they had been collected or delivered. Changes in dose or other issues were recorded on the patient’s electronic prescription record and the pharmacist looked at these during the checking stage.

The pharmacy ordered the regular monthly prescriptions for the care homes from a picking list. Copies of these were not sent to the homes for checking. The homes ordered the prescriptions for any changes. This situation increased the likelihood of errors. In addition, a faxed sheet was seen asking the pharmacy to order some items. No strengths or clear details were written on the sheet. The dispenser said that she ordered what the patient usually had. Some of the medicines for the homes were racked

but they did not give the pharmacy a monthly up-to-date racking list. The pharmacy staff were not sure what training the care home staff completed but the homes were visited annually. The pharmacy had no procedures in place to ensure that, any compliance aid patients receiving high-risk drugs, were having the required blood tests. The staff were aware of the new sodium valproate guidance. They currently had no people who may become pregnant prescribed this.

Assembled methadone was seen to have no completed dispensing audit trail. The pharmacist said that he did the assembly and checking of this. He said that in future he would initial the dispensing label. The pharmacist routinely counselled walk-in patients prescribed high-risk drugs such as warfarin and lithium. He asked about INR levels. He also counselled patients prescribed amongst others, antibiotics, new drugs 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 and these patients were counselled.

Signatures were not always obtained indicating the safe delivery of medicines. Several delivery driver sheets were seen. There were few signatures. As mentioned under principle 1, the delivery driver admitted that he posted compliance aids through the letterboxes of patients even after there had been a serious error at another branch where a dosette patient took the wrong medicines.

Medicines and medical devices were obtained from AAH, Alliance Healthcare and Badhams warehouse. Specials were obtained from The Specials Laboratory. Unlicenced vitamin B compound strong was seen on the dispensary shelves. The staff said that this was sent from the warehouse. The staff had received no training on the Falsified Medicines Directive and the pharmacy had no scanners to check for falsified medicines. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were three patient-returned CDs but no out-of-date CDs. These were clearly labelled and separated from usable stock. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins for storing waste medicines were available for waste and used.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 30 November 2018 about valsartan. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the appropriate equipment and facilities for the services it provides. But, better use of the space could be made for the specialist services it provides.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 to 100ml). There were three 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 2017/2018 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. Designated bins for storing waste were available and used and there was adequate storage for all other medicines.

The pharmacy computers were password protected. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential was 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.