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: 06/01/2020

Pharmacy context

This is a community pharmacy in the Cotswold village of Upper Rissington. The village has several new homes housing young families but most of the people who use the pharmacy are elderly. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It supplies medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines. The pharmacy also supplies medicines to local care homes.

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	N/A	N/A	N/A
2. Staff	Standards met	2.4	Good practice	The team members are encouraged to develop and keep their skills up to date and they are provided with dedicated time to do this at work.
		2.5	Good practice	The team are well supported by their manager. They are comfortable about providing feedback to her to improve services for patients, and she acts on 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's working practices are generally safe and effective. The team learns from their mistakes. The pharmacy keeps the up-to-date records that it must by law. It is appropriately insured to protect people if things go wrong. The pharmacy team keeps people's private information safe and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy team identified and managed most risks. Any dispensing errors and incidents would be recorded, reviewed and appropriately managed. The last error had been in 2018. The pharmacist said that there were few near misses but these were recorded. Learning points, such as, the two strengths of amoxicillin being mixed on the shelf and actions, to reduce similar recurrences, such as, clearly separating risperidone and ropinirole, were recorded. 'Look alike, sound alike' (LASA) drugs were identified and highlighted. The near miss log was reviewed each month.

The dispensary was tidy and organised. There were labelling, assembly and checking areas. A central bench was used for items waiting to be checked, deliveries or the racking of the care home prescriptions. Shelves above the assembly area were also used for the multi-compartment compliance aids or care home blisters waiting to be checked. Coloured baskets were used and distinguished prescriptions for patients who were waiting, those for collection, those for delivery and those for the care homes. 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.

Most of the medicines assembled by the pharmacy were delivered. Many of the delivery records showed that signatures had not been obtained from patients or their carers indicating that the medicines had been safely delivered. They had been initialled by the delivery driver.

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 continually reviewed by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. The company's sales protocol was displayed and included questions to be asked of customers requesting to buy medicines and when customers should be referred to the pharmacist, such as specific patient groups and those requesting multiple sales. This included local additions such as Viagra Connect. The medicine counter assistant trainee said that she would refer all 'pharmacy only medicines' (P medicines) to the pharmacist. A NVQ2 trained dispenser was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Ella One and referred requests for these to the pharmacist.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, 100% of people who completed the questionnaire were satisfied with the service at the pharmacy. 1% of people had commented on having somewhere private to talk. Because of this, the staff endeavoured to proactively offer customers the use of the consultation room.

Public liability and professional 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 in place and the staff had also completed training on the general data protection regulations. The computers, which were not visible to the customers, were password protected. 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. 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. And, the company provides additional support when team members are on holiday or of sick. The team members are encouraged to keep their skills up to date and they do this in work time. Those team members who are in training are well supported by the manager. The whole team are comfortable about providing feedback to her to improve services for patients and she acts on this.

Inspector's evidence

The pharmacy was in the Cotswold village of Upper Rissington. They mainly dispensed NHS prescriptions with the majority of the medicines being delivered to patients. Several domiciliary patients received their medicines in compliance aids and the pharmacy supplied medicines to the residents of two local care homes.

The current staffing profile was one pharmacist, the manager, newly appointed, one full-time NVQ2 qualified dispenser, one part-time NVQ2 trainee dispenser (not seen) and one part-time medicine counter assistant (MCA) trainee who hoped to do the dispensing assistant training in the near future.

The part-time dispenser had child care commitments but had some flexibility to cover any unplanned absences. The staff said that the company would provide help if necessary. Planned leave was booked well in advance and only one member of staff could be off at one time. This time too was generally covered by someone in the company.

The staff 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 could be identified. Review dates would be set to achieve this. The staff were encouraged with learning and development and completed e-Learning, such as recently on sepsis and diabetes. They spent about 30 minutes each month of protected time learning. The MCA trainee was allocated a further 30 minutes each week of learning time for her course. The dispenser seen said that she was supported to learn from errors. The pharmacist said that all learning was documented on her continuing professional development (CPD) record.

The staff knew how to raise a concern and reported that this was encouraged and acted on. A qualified dispenser had recently raised issues with the ordering of special items for customers. Because of this, the pharmacy now wrote these in a dedicated book. The staff recorded if they were unable to obtain a particular item so, when the person came in, they were able to report this. Previously they wasted time trying to locate the item. There were monthly staff meetings where written notes were taken.

The pharmacist said that she was set targets, such as, for Medicines Use Reviews (MURs) but that there was a low footfall at the pharmacy and she was not unduly pressured to achieve these. She said that she tried to do as many extra clinical services that she could.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional and is suitable for the services it provides. It signposts its consultation room so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was well laid out and presented a professional image. The dispensing benches were uncluttered and the floors were clear. The premises were clean and well maintained. There was a signposted bell on the front door for wheelchair users but this was not working. The pharmacist said that she would check the batteries.

The consultation room was small but the door opened outwards and so access by the emergency services, if necessary, should not be impeded. The room was signposted and contained a computer and a small sink. Conversations in the consultation room could not be overheard. The pharmacy computer screens were not visible to customers but the design of the consultation room meant that the screen in here may be difficult to obscure. 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 met

Summary findings

People can access the services that the pharmacy offers. The services are generally effectively managed to make sure that they are provided safely. The pharmacy team members make sure that people have the information that they need to take their medicines properly. They intervene if they are worried. The pharmacy mainly gets its medicines from appropriate sources. The medicines are stored and disposed of safely.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but the bell on the front door for their use was not working. The staff could access an electronic translation application for use by non-English speakers. The staff spoke Chinese and Italian. 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), Community Pharmacy Consultation Service (CPCS), the Gloucestershire urgent repeat medicine service and seasonal flu vaccinations. The latter was also provided under a private scheme. 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. She had also completed training on the CPCS service but to date the pharmacy had not received any referrals.

The majority of the business at the pharmacy was the assembly of medicines into compliance aids for domiciliary patients and the assembly of medicines for the residents of two care homes (nursing and residential). The domiciliary compliance aids were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were dedicated colour-coded folders for these patients. All changes or other issues were recorded on the patient's electronic prescription medication record (PMR). These were printed off for easy referral by the pharmacist at the checking stage. The assembled compliance aids were stored tidily.

The pharmacy ordered the regular repeat items for the care home residents from a list provided by the homes. They sent copies of the prescriptions to the homes for checking. Any new items were ordered or chased by the homes. The pharmacy did not receive written confirmation, either from the appropriate surgery, or from the homes, about changes. They were also responsible for chasing any missing items. The pharmacy was also responsible for making sure that any patients prescribed high-risk medicines were having the required blood tests. The homes did not send the pharmacy a monthly up-to-date racking list. The pharmacy team would provide any necessary advice over the phone but they were not sure what training the staff at the care homes had received. Any communications with the homes was recorded on the patient's PMR. The homes were said to be visited annually.

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 PMR. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded. She also counselled patients prescribed amongst others, antibiotics, new drugs

and any changes. CDs and insulin were checked with the patient on hand-out. The staff were aware of the sodium valproate guidance relating to the pregnancy protection program (PPP). They had identified one person who was in the at risk group. She had been counselled and guidance leaflets were included with each prescription for her.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were not always obtained indicating the safe delivery of medicines (see under principle 1). 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 taking their statins in the evening. She explained the reason why they should do so.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, Phoenix and Badhams Warehouse. The latter provided some unlicenced medicines, such as, thiamine 100mg. The pharmacist said that she would discuss this issue with the superintendent. Specials were obtained from the Specials Laboratory. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were a few patient-returned 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 electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes.

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. But, the pharmacy was unaware of the recent alert about Emerade pens. The pharmacist signed the pharmacy up to receive alerts directly from the Medicines and Healthcare products Regulatory agency (MHRA).

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 100ml). There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 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 (see under principle 3). There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste 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.