General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Badham Pharmacy Ltd, 45 - 47 Filwood Broadway, Knowle, Bristol, Somerset, BS4 1JL

Pharmacy reference: 9010874

Type of pharmacy: Community

Date of inspection: 19/02/2020

Pharmacy context

This is a community pharmacy in the southern suburbs of the city of Bristol. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy supplies many medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines.

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	The pharmacy does not identify and manage the risks to patient safety resulting from poor staffing levels. These have been cited as a precipitating cause in two recent dispensing errors.
		1.2	Standard not met	There is insufficient reflection and learning to prevent mistakes from happening again.
		1.6	Standard not met	The pharmacy does not keep the up-to-date records that it must by law.
		1.7	Standard not met	The pharmacy team members do not keep people's private information safe. They keep confidential information in an easily accessible, unlocked room.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough staff to manage its workload safely. And, this may have been a contributing factor to two recent errors.
		2.4	Standard not met	The pharmacy team have no time to complete any on-going learning at work. And, those team members who are in training are not adequately supported with their courses.
		2.5	Standard not met	The pharmacy team are not supported by the higher management. They have consistently raised legitimate concerns about the staffing levels which have not been addressed.
3. Premises	Standards not all met	3.5	Standard not met	The consultation rooms and the staff toilets are not adequately heated. This means that these areas are not comfortable, either for the people wanting private conversations, or, for the team members who need to use the facilities.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not store all its medicines safely. And, some medicines are not subject to recognised standards. This means that people may not be getting medicines of a desired quality.

Principle	Principle finding	Exception standard reference	Notable practice	Why
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy does not identify and manage the risks to patient safety resulting from poor staffing levels. These have been cited as a precipitating cause in two recent dispensing errors. This also shows that there is insufficient reflection and learning to prevent these from happening again. The pharmacy team members do not keep people's private information safe. They keep confidential information in an easily accessible, unlocked room. And, they do not keep the up-to-date records that they must by law. The pharmacy is appropriately insured to protect people if things go wrong. The team members know how to protect vulnerable people.

Inspector's evidence

Not all risks were suitably identified and managed by the pharmacy. This was the case with the previous inspection visit on 5 July 2019. Following a re-visit on 2 September 2019, the pharmacy was deemed to be mainly compliant with the GPhC's standards for registered pharmacy premises. The current visit was to ascertain that the compliance with standards had been maintained.

Dispensing errors and incidents were recorded. But, in two recent errors, in December 2019 and January 2020, staffing levels had been identified as precipitating factors. Staffing levels had been identified as an issue in the previous visit on 5 July 2019. Near misses were recorded and staffing levels were also identified as an issue, such as mirtazapine 15mg being picked instead of meloxicam. It was recorded that the dispenser was working on her own and also trying to cover the medicine counter. The previous pharmacy manager had left in December 2019 because of poor staffing levels and lack of support from higher management. The near miss log was signed as being reviewed but the staff said that the findings were not discussed with them.

The dispensing areas were spacious. There was a main dispensary with labelling, assembly and checking areas and a separate area for the multi-compartment compliance aids. Many items were seen to be waiting to be checked by the pharmacist. A relief accuracy checking technician (ACT) did work at the pharmacy but just one day a week. At the time of the visit, the pharmacy was behind their work schedule for compliance aids (see further under principle 2 and 4). The pharmacy was busy and a large proportion of their business would be regarded as 'high-risk', that is, many compliance aids and many supervised substance misuse patients.

Coloured baskets were used and distinguished prescriptions for patients who were waiting, those calling back, those for collection and those for delivery. There was a clear audit trail of the dispensing process and most of the 'dispensed by' and 'checked by' boxes on the labels examined had been initialled (see further under principle 4).

Signed standard operating procedures (SOPs), were in place but these were due for review in January 2020. The superintendent sent an email on 19 February 2020 stating that this process had started. 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 but it did not include any local additions and it was not dated. However, the medicine counter assistant said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She 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 knew that fluconazole capsules should not be sold to women over the age of 60 for the treatment of vaginal thrush.

The staff said the pharmacy had a complaints procedure and that feedback on concerns was encouraged. The pharmacy did an annual customer satisfaction survey, the community pharmacy questionnaire (CPPQ). However, they were not aware of the results of the most recent survey. They said that most complaints they received were about waiting times. These, they said were mainly due to the staffing levels, but they did try to give patients waiting for prescriptions realistic waiting times, suggested that they called back or offered to have the medicines delivered.

Public liability and professional indemnity insurance, provided by the National Pharmacy Association (NPA) and valid until 30 November 2020, was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, emergency supply records, specials records, fridge temperature records and date checking records were all in order. The latter were behind schedule indicating insufficient staff to do this task. The private prescription record book had a gap in the records from 6 July 2019 until 29 January 2020. The electronic private prescription register showed several prescriptions to have been dispensed in this time period. But, many of these had no prescriber details.

There was said to be an information governance procedure in place but this was not on the premises at the time of the visit. And, patient confidential information was being stored in an unlocked consultation room. This room was easily accessible by the public (see further under principle 3). The pharmacist, very newly appointed (two weeks), had completed training on the general data protection regulations. The staff said that they were due to training on this. The pharmacy computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was disposes of appropriately. No conversations could be overheard in the consultation rooms when the doors were closed.

The staff understood safeguarding issues and had read the company's policy on the safeguarding of both children and vulnerable adults. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers to escalate any concerns relating to both children and adults were available online.

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

Summary findings

The pharmacy does not have enough staff to manage its workload safely. And, this may have been a contributing factor to two recent errors. In addition, the pharmacy team are not supported by the higher management. They have consistently raised legitimate concerns about the staffing levels which have not been addressed. The pharmacy team have no time to complete any on-going learning at work. And, those team members who are in training are not adequately supported with their courses.

Inspector's evidence

The pharmacy was in the southern suburbs of the city of Bristol. They dispensed many items, mainly against NHS prescriptions. A large proportion of the business at the pharmacy was the assembly of medicines into domiciliary compliance aids. The pharmacy also had a large number of supervised substance misuse patients.

The current staffing profile was one pharmacist (very newly appointed – two weeks), one full-time NVQ3 qualified technician (not seen – on holiday), two full-time NVQ2 qualified dispensers (one, a NVQ3 trainee technician), one part-time NVQ2 trainee dispenser, two part-time medicine counter assistants (MCAs), one Saturday person and two part-time delivery drivers. A relief accuracy checking technician (ACT) worked at the branch on one day each week, but not on the same day each week. This meant that it was difficult for the staff to plan their workload and also meant that the pharmacist was required to check several compliance aids, some of which were seen to have be checked by him before the next day. At the follow-up inspection on 2 September 2019, assurance was given that all the compliance aids would be checked by an ACT. And, as mentioned under principle 1, at the time of the visit, many non-compliance aid prescriptions were seen to be waiting to be checked. This indicated overall insufficient checking resource at the pharmacy and was a precipitating reason for the former manager leaving the pharmacy. She had left in the middle of December 2019 and locum pharmacists had been employed until two weeks before the visit. The previous manager had raised concerns about staffing levels with the superintendent in September 2019 and had also informally raised this concern with inspector. All the staff said that they constantly raised concerns about staffing with the superintendent. In addition, the staff said that the superintendent had contacted a local surgery to say that the pharmacy could take on more domiciliary compliance aid patients even though it was clear that there were insufficient staff for them to safely cope with their current workload.

The staff reported that they received no help from the company to cover either planned or unplanned absences. With regard to holidays, they said that they tried to work ahead of schedule to accommodate these. The part-time MCAs were usually able to cover each other.

The staff did have annual appraisals. They were signed up to an e-Learning programme but were unable to do this learning in work time due to workload pressure. Those staff enrolled on accredited courses, such as the NVQ3 technician's course, were not allocated any dedicated learning time towards their courses. The pharmacist said that all learning was documented on his continuing professional development (CPD) record. He said that he was not set targets for advanced NHS services but that he was put under some pressure to increase prescription items. The pharmacy already dispensed a large number of these.

Principle 3 - Premises **Standards not all met**

Summary findings

Some areas of the pharmacy look professional and it is generally suitable for the services it provides. But, the consultation rooms and the staff toilets are not adequately heated. This means that these areas are not comfortable, either for the people wanting private conversations, or, for the team members who need to use the facilities. The consultation rooms were signposted but this was not easily visible when people entered the pharmacy.

Inspector's evidence

The pharmacy was well laid out and spacious. But, at the time of the inspection, there were several baskets waiting to be checked and so the dispensing benches were cluttered. This was mainly due to the issues mentioned under principle 2. The pharmacist was aware of this risk and only placed one basket at a time in the checking area to mitigate this risk. The floors were largely clear. The premises were clean. But, both the male and female toilets were very damp and the paint and plaster was peeling off the walls. In addition, there was mould growing on the wall in the female toilet. Neither toilet had any heating. This was also the case with both of the consultation rooms.

Both consultation rooms were small. They were signposted on the doors but this was not visible to people entering the pharmacy. And, confidential information (see under principal 1) and medicines (see under principle 4) were stored in the rooms. Both rooms were unlocked and easily accessible by the public. The location of the rooms meant that it would be very difficult for the staff to see if anyone accessed these rooms.

The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot. There was air conditioning and heating but not in the toilets or the consultation rooms. 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 generally manages its services satisfactorily, but the team members don't always counsel those people who are prescribed high-risk medicines. So, the team may not be identifying any side effects and the people may not be taking these medicines properly. The pharmacy does not store all its medicines safely. And, some medicines at the pharmacy are not subject to recognised standards. This means that people may not be getting medicines of a desired quality. The pharmacy team could also make sure that there is a robust audit trail showing that they have acted appropriately on any concerns about medicines or devices to 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 rooms but no bell on the front door alerting staff to anyone who may need assistance entering the pharmacy. The staff could access an electronic translation application 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) and supervised consumption of methadone and buprenorphine. The pharmacist reported that he had little time to do any MURs (see under principle 2). He said that he had been able to do a couple of NMS reviews.

A large number of substance misuse patients had their medicines supervised. These were assembled from a Methasoft machine. However, very few photographs of the clients were uploaded. This meant that the full functionality of the software, to ensure that medicines were given to the correct patient, was not made. There was a dedicated folder for these patients where any relevant information was kept. But, the telephone numbers of key workers were not available. The pharmacy was open for longer hours than the service provider and so these would be useful. The newly employed pharmacist said that he would try to get these. The patients were offered water or engaged in conversation to reduce the likelihood of diversion.

Many domiciliary patients received their medicines in compliance aids. These were assembled and checked in a spacious, separate area but as mentioned in principles 1 and 2, the checking of these was behind schedule. The compliance aids were mainly assembled on a four-week rolling basis and evenly distributed throughout the week to try to manage the large workload. There were dedicated folders for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. But, there was no concise audit trail of changes or other issues for easy reference by the pharmacist or the ACT at the checking stage. The assembled compliance aids were stored tidily with those for collection and those for delivery clearly separated.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for most items dispensed by the pharmacy. But, the dispensing audit trail for the high-risk medicine, methotrexate, had not been completed. Green 'see the pharmacist' stickers were said to be used but patients prescribed high-risk drugs such as warfarin, lithium and methotrexate were not routinely

counselled. International normalised ratios (INR) were not recorded. The pharmacist did counsel patients prescribed antibiotics, new drugs and any changes. CDs and insulin were packed in clear bags, but the staff said that they were not routinely checked with the patient on hand-out. One member of staff was aware of the sodium valproate guidance relating to the pregnancy protection programme. The newly appointed pharmacist said that he would do an audit of the 'at risk' patients and would counsel any identified patients. Guidance cards were available. 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.

Medicines and medical devices were generally obtained from reputable wholesalers. But unlicensed medicines, such as thiamine 100mg, was sent from the company's warehouse. Invoices for all these suppliers were available. A scanner was not available to check for falsified medicines as required by the Falsified Medicines Directive (FMD). CDs were stored in accordance with the regulations and access to the cabinets was appropriate. But, there were several patient-returned CDs and out-of-date CDs. These were clearly labelled and separated from usable stock but occupying valuable space in the cabinet. The pharmacist said that he had no time to destroy the patient-returned CDs. Appropriate destruction kits were on the premises. In addition, the safe used for the storage of some CDs, would benefit from an additional shelf to prevent baskets being stored on top of one another.

One of the consultation rooms was being used for the storage of labelled assembled compliance aids. Prescriptions were included. Other electronic prescriptions were also seen in here. The room was not locked. Adrenaline injection and nicotine replacement products were seen to be stored in the other consultation room. This too was not locked. Fridge lines were correctly stored with electronic records. Date checking procedures were behind schedule. 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. But, the list was dated 2012.

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. Not all actions were recorded, such as an alert received on 3 February 2020 about ranitidine tablets. One dispenser believed that the pharmacy did have some of the affected batches but this was not recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services its 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 - 250ml). 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 Methameasure machine was cleaned and calibrated daily. The pharmacy computers were password protected and 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 waste information was disposed of appropriately. 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.