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: 14/09/2020

Pharmacy context

This is a community pharmacy in a shopping area in the southern suburbs of the city of Bristol. A wide variety of people visit the pharmacy but most people are elderly. The pharmacy team members dispense prescriptions, sell over-the-counter medicines and give advice. They also supply several medicines in multi-compartment compliance packs to help vulnerable people in their own homes to take their medicines. The pharmacy offers Medicines Use Reviews (MURs), the New Medicine Service (NMS), the Community Pharmacy Consultation Service (CPCS), seasonal flu vaccinations and several other services. The inspection was carried out during the COVID-19 pandemic.

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	N/A	N/A	N/A
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 safe and effective. It has made changes to its written procedures as a result of COVID-19. And, physical measures are in place to reduce the risk of transmission of coronavirus. The pharmacy is appropriately insured to protect people if things go wrong. It keeps the required records. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy team members identified and managed the risks associated with providing its services. They had put several changes in place, as a result of the COVID-19 pandemic, to reduce the risk of transmission of coronavirus. The pharmacy had updated its standard operating procedures (SOPs) with changes relating to the pandemic. The pharmacy had updated its business continuity plan to accommodate any potential issues relating to the current NHS 'test and trace' scheme. It was part of a larger group of pharmacies but with no other premises close by. The superintendent said that he would liaise with another close by pharmacy to ensure that there was no disruption in the supply of medicines to their patients if the pharmacy had to close. The pharmacist manager (not seen) had conducted risk assessments of the premises and occupational risk assessments of all the staff. The team members were asked about any potentially vulnerable people in their households. The manager reviewed the risk assessments each month. The pharmacy team members were aware that they needed to report any COVID-19 positive test results.

The pharmacy team members recorded near miss mistakes, that is, mistakes that were detected before they had left the premises. They documented learning points but few specific actions to prevent any future recurrences. The dispensary team reviewed and discussed the near miss log each month. They had recently reviewed common 'look alike, sound alike' (LASA) mistakes. The team had placed shelf-edge stickers where these products were stored on the dispensary shelves. The pharmacy had had no recent errors where the incorrect medicines had left the pharmacy.

The dispensary was spacious, tidy and organised. There were dedicated working areas, including a clear checking bench. The staff placed the prescriptions and their accompanying medicines into baskets to reduce the risk of errors. They also used different coloured baskets to distinguish the medicines for people who were waiting, those who were calling back and those for delivery. This allowed the pharmacist to prioritise the workload.

All the staff were clear about their roles and responsibilities. A medicine counter assistant (MCA) reported that there had been increased requests for codeine-containing medicines since the outbreak of the pandemic. Because of this, the pharmacy team had removed items such as Solpadeine Max and Nurofen Plus from view of customers. The pharmacy team members referred any medicine sale requests for children under two or those for people with a persistent cough to the pharmacist.

The pharmacy team were clear about their complaints procedure. They had not received any complaints since the outbreak of the pandemic. All the recent feedback from people using the pharmacy had been positive. They were grateful for the hard work and dedication of the pharmacy

team in the recent difficult circumstances.

The pharmacy had current public liability and indemnity insurance provided by the National Pharmacy Association (NPA). It kept the required up-to-date records: the responsible pharmacist (RP) log, controlled drug (CD) records, private prescription records, emergency supply records and specials records. The pharmacy also had fridge temperature records, date checking records, patient-returned CD records and cleaning rotas.

All the staff understood the importance of keeping people's private information safe. They stored all confidential information securely. The computers, which were not visible to the customers, were password protected. The correct NHS smartcards were seen in the appropriate computers. The pharmacy team members shredded all confidential wastepaper. The pharmacy offered face-to-face services. These were done in the consultation rooms. People could not be overheard or seen in the consultation rooms.

The pharmacy team understood safeguarding issues. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. The pharmacy had local telephone numbers to escalate any concerns relating to both children and adults. The superintendent said that he would register all the pharmacies in the group to the national 'safe space' initiative for victims of domestic violence.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage their workload safely. And the company provides additional help if necessary. The pharmacy team members are encouraged to keep their skills and knowledge up to date. And they are kept informed about changes in advice relating to COVID-19. The team members work well together. They are comfortable about providing feedback to their manager to improve their services and this is acted on.

Inspector's evidence

The pharmacy's current staffing profile was: one pharmacist, one full-time accuracy checking technician (ACT), one full-time NVQ2 qualified dispenser, two part-time NVQ2 qualified dispensers, one full-time medicine counter assistant (MCA) and one full-time driver. A qualified dispenser had recently left but her hours had been covered by a locum dispenser. A new team member had been appointed and she will start work in October. The part-time staff were flexible and generally covered any unplanned absences. They had more flexibility during school times. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff worked well together as a team. The manager (not seen) monitored the performance of the team members. They had an annual appraisal with a six-monthly review where any learning needs could be identified. Review dates would be set to achieve this. They had a staff meeting every month and notes about this were taken. All the staff felt able to raise any issues or concerns with the manager and said that these would be acted on. The dispensary team members had recently raised an issue with the use of the space in the dedicated multi-compartment compliance pack area. As a result of this, they had rearranged the storage of the completed packs. This allowed the central island unit to be used more efficiently for the assembly and checking of the compliance packs. And hence overall greater efficiency of the service.

The staff were encouraged with learning and development. They completed regular e-learning, such as recently on vaccines. Some of this learning was completed in work time. The team members were also informed of all the updates and current advice regarding coronavirus. All the dispensary staff reported that they were supported to learn from errors. The GPhC registrants documented all learning on their continuing professional development (CPD) records.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional and is suitable for the services it offers. It is clean, tidy and organised. The premises are thoroughly cleaned to reduce the likelihood of transmission of coronavirus.

Inspector's evidence

The premises presented a professional image. It was spacious, tidy and organised. The dispensing benches were uncluttered and the floors were clear. The pharmacy had a separate area where the staff assembled and checked the compliance aids. This too was tidy and organised. The premises were clean. As a result of COVID, the premises were thoroughly cleaned every day. All the hard surfaces were wiped over more frequently than this. The pharmacy team members used alcohol gel after each interaction with people.

The pharmacy had two signposted consultation rooms. People could not be seen or overheard in these rooms. The pharmacy’s computer screens were not visible to customers. The telephone was cordless and the staff took all sensitive calls out of earshot. The temperature in the pharmacy was below 25 degrees Celsius and it was well lit.

Principle 4 - Services ✔ Standards met

Summary findings

Everyone can access the services the pharmacy offers. It manages its services effectively to make sure that they are delivered safely. The pharmacy is offering face-to-face services including flu vaccinations. It uses an electronic application which reduces the direct contact time of the person with the pharmacist. This in turn reduces the risk of infection with coronavirus. And it increases the flu vaccination capacity of the pharmacy. The pharmacy team members make sure that people have the information they need to use their medicines properly. The pharmacy gets its medicines from appropriate sources and stores them safely. The pharmacy makes sure that people only get medicines or devices that are safe.

Inspector's evidence

Everyone could access the pharmacy and the consultation rooms. The pharmacy team members could access an electronic translation application for any non-English speakers. The team members could print large labels for sight-impaired people.

The pharmacy was located in the southern suburbs of the city of Bristol. Most of its prescriptions were electronically transferred from local surgeries and most were for local residents. The dispensary staff initialled the ‘dispensed by’ and ‘checked by’ boxes on the labels, so providing a clear audit trail of the dispensing process.

In addition to the essential NHS services, the pharmacy offered several additional services: Medicines Use Reviews (MURs), New Medicine Service (NMS), the NHS emergency hormonal contraception (EHC) service, Community Pharmacy Consultation Service (CPCS) and a flu vaccination service (NHS and private). The CPCS scheme was operated in association with a GP pilot study. In addition, the pharmacy offered several local services, such as detection and treatment of urinary tract infections, hydrocortisone for use on the face and the use of chloramphenicol for the treatment of bacterial conjunctivitis in children under two. The pharmacist manager (not seen) had completed the appropriate training to provide these services.

The pharmacist had started providing flu vaccinations. The NHS in the south-west had funded a new electronic means of pre-populating the flu pre-assessment form for the vaccinations. It was called PreConsult. The application allowed the form to be pre-populated ahead of the pharmacist consultation. PreConsult could be used in two different ways. Patients could scan a QR code (a two-dimensional version of a barcode made up of black and white pixel patterns), on their own smartphone and enter their own information. Or, the pharmacy team members could enter the patient information, in the pharmacy or during a telephone booking. By reducing the pharmacist/patient contact time, PreConsult helped to reduce the infection risk and to increase the capacity of the pharmacy to deliver a larger number of vaccinations. The Avon Local Pharmaceutical Committee (PLC) had provided a webinar on PreConsult and also advice about the use of personal protective equipment (PPE). Pharmacists were advised to wear type 2 fluid resistant masks and face shields for each session of vaccinations. The pharmacist used alcohol gel or washed his hands before and after each vaccination. Everyone who received the vaccine wore a face covering.

The pharmacy had several substance misuse clients who usually had their medicines supervised. Due to COVID-19, most of these clients now collected their medicines. A few were still supervised. This took place in a dedicated area at the front of the dispensary. Supervised methadone was dispensed from a Methameasure machine. The client disposed of the container themselves into a dedicated bin. All the clients were offered water or engaged in conversation to reduce the likelihood of diversion. The pharmacy had a dedicated folder where any concerns or issues about the clients were recorded. The clients' key worker telephone numbers were also recorded.

The pharmacy had several domiciliary people who had their medicines in compliance packs. All these people were vulnerable and would not cope with their medicines in original packs. The staff kept dedicated folders where they recorded any changes in dose or other issues. The pharmacist referred to these when doing the final accuracy check. The dispensary team assembled and checked the compliance packs in an organised separate area. The assembled packs were stored tidily.

The dispensary team highlighted any prescriptions containing potential drug interactions, changes in dose or new drugs to the pharmacist. The regular pharmacist (not seen) targeted anyone he was concerned about for counselling. The locum pharmacist seen counselled people prescribed high-risk drugs such as warfarin and lithium and also those prescribed antibiotics, new items or complex doses. All pharmacy team members were aware of the pregnancy protection programme regarding sodium valproate. The pharmacy currently had no 'at risk' patients who were prescribed sodium valproate.

The pharmacy delivered several medicines to people. Because of the pandemic, the delivery driver did not currently ask people to sign for their medicines to indicate that they had received them safely. She knocked or rang the doorbell and left the medicines on the doorstep. The driver retreated and waited until the medicines had been taken safely inside. She annotated the delivery sheets accordingly.

The pharmacy got its medicines from Alliance Healthcare, AAH and Badhams Warehouse. Invoices for all these suppliers were available. The pharmacy had no scanner to check for falsified medicines as required by the Falsified Medicines Directive (FMD). It stored its CDs tidily in a large safe. Staff access to the safe was appropriate. The pharmacy had no out-of-date CDs. It had one patient-returned CD which was clearly labelled and separated from usable stock. Appropriate CD destruction kits were on the premises. The pharmacy stored its fridge lines correctly and it had date checking procedures. The pharmacy team members were accepting patient-returned medicines. These were not being double bagged. The inspector signposted the staff to recent published advice about accepting patient-returned medicines during the pandemic.

The pharmacy had procedures for dealing with concerns about medicines and medical devices. The pharmacy received drug alerts electronically. They were printed off and the stock was checked. The pharmacy had received an alert on 1 September 2020 about apixaban. It had none of the affected batches in stock and this was recorded.

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. The pharmacy has taken action to reduce the spread of coronavirus with changes to its flow of people and the use of protective screens and equipment.

Inspector's evidence

As a result of the pandemic, the pharmacy had created a clear one-way system both in the retail area and in the dispensary. Robust Perspex screens had been erected across the entire medicine counter and also across the area where the substance misuse clients were served. The pharmacy had a portable protective screen which was used in the consultation room. A hole had been cut out of this for the flu vaccinations. The person receiving the vaccination placed their arm through the hole.

Not all the staff were wearing Type 2R fluid resistant face masks or face shields. They could however largely remain two metres apart from each other. The pharmacist wore a mask and also eye protection when he vaccinated anyone against flu. This protection was used for each session of vaccinations.

The pharmacy used British Standard crown-stamped conical measures. There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. The fridge was in good working order and maximum and minimum temperatures were recorded daily. The dispensary team cleaned and calibrated the Methameasure machine each day. The pharmacy had up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children’s BNF. The staff could access to the internet.

The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and the staff took any sensitive calls out of earshot. The pharmacy team members shredded all confidential waste information.

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.