General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Badham Pharmacy LTD, Kingsway Medical Centre, Rudloe Drive, Kingsway, Gloucester, Gloucestershire, GL2 2FY

Pharmacy reference: 9011058

Type of pharmacy: Community

Date of inspection: 31/07/2019

Pharmacy context

This is a newly opened community pharmacy in a doctor's surgery. It is situated in residential area of new housing close to the centre of Gloucester. Many of the people visiting the pharmacy are young families. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It also supplies medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines and supplies medicines to people in three local nursing homes.

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 generally safe and effective. The team learn from mistakes to prevent them from happening again. They ask customers for their views but do not always act on the negative feedback to improve their service. The pharmacy keeps the up-to-date records it must by law. It is appropriately insured to protect people if things go wrong. The pharmacy team keep people's private information safe and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy team identified and managed most risks. Dispensing errors and incidents were recorded, reviewed and appropriately managed. The last error was in June 2019. Spironolactone 25mg had been given instead of levothyroxine 25mcg. The spironolactone was packaged in very similar livery to the levothyroxine and had been put on the shelf in the wrong place. The staff had been told to take extra care when putting stock away and to highlight any issues of identical or similar packaging. Some strengths of medicines had been separated with card to reduce the likelihood of picking errors with these, such as, codeine 15mg and 30mg. Near misses were recorded but some included insufficient information to allow useful analysis, such as, an error where lamotrigine 50mg had been given instead of topiramate 50mg. General trends were however identified, such as, in June 2019 with strength errors. Several mistakes were due to assuming that the prescription was for the common strength, like omeprazole 20mg.

The dispensary had labelling, assembly and checking areas. There was also a central bench that was used for deliveries and for stock that had to be put away. One small bench was allocated to monitored dosage system prescriptions. This was small for the workload.

Coloured baskets were used and distinguished prescriptions for people who were waiting, those for delivery, electronically transferred prescriptions and prescriptions 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.

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 were clear about their roles. There was no displayed company's sales protocol but the questions to be asked of customers requesting to buy medicines, was displayed. A qualified dispenser, currently enrolled on the NVQ3 trainee technician course, 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 knew about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. 98% of people who had completed the questionnaire were satisfied with the service from the pharmacy, But, 10% had

commented on the comfort and convenience of the waiting areas. The pharmacy only had two folding, garden-like chairs.

Public liability and indemnity insurance provided by the National Pharmacy Association 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 and the staff had also completed training on the new data protection regulations. The computers in the dispensary were not visible to the customers but the design of the consultation room meant that it was difficult to obscure the screen in here. The pharmacist was aware of this and said that he always turned the screen away from the person in the consultation room so that they could not see the screen. The computers were password protected. 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 to escalate any concerns relating to both children and adults were available. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough staff to manage its workload safely. But, there are periods in the day where the levels are low and this could increase the risks of mistakes. The company provides help when people are on holiday. The team members are encouraged to keep their skills up to date and they do this in work time. The pharmacy team are well supported by their immediate manager. They are comfortable about providing feedback to him to improve services and this is acted on.

Inspector's evidence

The pharmacy was situated in a doctor's surgery in a residential area of new housing on the outskirts of Gloucester. They dispensed approximately 5,000 NHS prescription items each month with the majority of these being repeats. 15 patients receiving care in their own homes and 96 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, the manager, one full-time NVQ2 trained dispenser, enrolled on the NVQ3 technician course and one part-time NVQ2 trainee dispenser, newly enrolled, who mainly covered the medicine counter. There were also two part-time delivery drivers. The pharmacy occasionally received help from an accuracy checking technician.

The part-time trainee dispenser was flexible and tried to cover unplanned absences. Planned leave was booked well in advance and only one member of staff could be off at one time. Most holiday was covered by relief staff in the company but unplanned sickness sometimes caused issues. About a month ago, the trained dispenser was ill and the pharmacist was left on his own with the trainee dispenser for a few hours. In addition, after 4pm there was only the pharmacist and the trained dispenser working. The pharmacist had no trained dispenser working with him from 8.30am until 9.00am and so was required to do self-checking in this time. The trainee dispenser had only just been enrolled on the dispensing assistant course and she was inexperienced. At the time of the inspection, the only dispensary duties she was doing was putting stock away. The trained dispenser was seen to have to interrupt her work, trying to assemble the medicines for a care home, on several occasions, to deal with prescription queries and people who had come to collect the medicines against electronically transferred prescriptions. This increased the risk of errors. On the day of the inspection, the pharmacy was not behind with their workload. But, they have been in the past. In June 2019, they had to rack the medicines for a home on the day that they were due to be delivered.

Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal. The trained dispenser had asked about the technician's course and she was enrolled on this in September 2018. She did however say that because of the staffing levels, it was difficult to spend much work-time on her course. She also said that the pharmacist tried to help her as much as workload pressures would allow.

The staff were encouraged with learning and development and completed Virtual Outcomes training, such as, on dementia and the new data protection regulations. They completed this training in work-time. The pharmacist said that all learning was documented on his continuing professional development (CPD) record.

The staff knew how to raise a concern and reported that this was encouraged. They said that they were well supported by their pharmacist manager. There were weekly staff meetings and the team members said that they felt able to raise any issues with their manager which he acted on to improve services.

The pharmacist said that he was set overall targets, such as 400 annual medicine use reviews (MURs). He reported that he only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is newly built. It looks professional. But, there could be more work space for its care home services and its services to help vulnerable people in their own homes to take their medicines. There is good signposting to the consultation room so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was newly built. There were dedicated work areas, but better provision could have been provided for the multi-compartment compliance aid services at the time of the planning of the pharmacy. One work bench was allocated to these services which was small for the workload. The pharmacy provided compliance aid services to several patients in their own homes and many residents of care homes. The premises were clean and well maintained.

The consultation room was quite spacious and well signposted. It contained a contained a computer and a sink. There were two chairs in this room but they were covered with fabric. This could make cleaning difficult. Conversations in the consultation room could not be overheard. The 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 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. But, the procedures for the ordering of prescriptions and, for any medicine changes for people in care homes, could pose a risk of mistakes. The pharmacy team make sure that people have the information they need to use their medicines safely and effectively. The pharmacy generally gets its medicines from appropriate resources. But, some medicines from the company's warehouse are not tested to recognised standards and this may pose a risk to people. The 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 with an automatic opening front door. 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), the New Medicine Service (NMS), emergency hormonal contraception (EHC), urgent repeat medicine scheme 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.

A large proportion of the business at the pharmacy was the assembly of medicines into multi-compartment compliance aids. 12 patients in their own homes and 15 residential home patients had their medicines assembled into compliance aids. 96 nursing home patients (3 homes) had their medicines in compliance aids which were racked. The pharmacy had no accuracy checking technician. One dispenser was responsible for the assembly of these prescriptions. She was seen to have to interrupt her work to deal with general prescriptions and queries. This increased the risk of errors. In addition, as mentioned under principle 3, there was little space allocated for the assembly of all the compliance aids.

The compliance aids for patients in their own homes were assembled on a four week rolling basis. Changes in dose or other issues were not recorded and so the pharmacist checking the compliance aids did not have a clear clinical picture of the patient. 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 pharmacy was not told in writing by the surgery of any changes or other issues. The pharmacy did not use communication diaries to record any queries. The homes did send the pharmacy a monthly up-to-date racking list. The pharmacy team were not sure what routine training the nursing home staff received. The pharmacist provided any necessary advice and counselling by telephone. The pharmacy had no procedures in place to ensure that, any compliance aid patients receiving high-risk drugs, were having the required blood tests.

All prescriptions containing new items, changes in dose or potential drug interactions were highlighted

to the pharmacist and these patients were counselled. ‘See the pharmacist’ stickers were used. The pharmacist counselled all 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, steroids and any changes. CDs and insulin were checked with the patient on hand-out. Only the pharmacist was aware of the new sodium valproate guidelines. He gave assurances that all his staff would be trained on these. The pharmacist said that he frequently identified, during MURs, that elderly patients prescribed anti-coagulants did not know what side effects to look out for. He gave them advice about this. Signatures were obtained indicating the safe delivery of medicines and owing notes were issued to patients for any items that were owed to them.

Medicines and medical devices were obtained from AAH, Alliance Healthcare and Badhams warehouse. Specials were obtained from The Specials Laboratory. Several unlicenced medicines were seen on the dispensary shelves, such as, vitamin B compound strong, thiamine 100mg and folic acid 400mcg. The staff said that these were sent from the company’s warehouse. The staff had received no training on the Falsified Medicines Directive and the pharmacy had no scanners to check for falsified medicines. Controlled drugs (CDs) were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no patient-returned CDs but a few 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. Bins were available for waste and used. There was a list of cytotoxic and cytostatic substances that are considered hazardous for waste purposes. The pharmacy had no dedicated bin for these but said that any of these substances would be appropriately separated prior to collection for disposal.

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. The pharmacy had received an alert on 30 July 2019 about aripiprazole 1mg/ml solution. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services it provides.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 to 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) 77 and the 2018/2019 Children's BNF. There was access to the internet. The fridge was in good working order but small for the amount of stock. Maximum and minimum temperatures were recorded 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 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.