General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Badham Pharmacy, Cleevelands Medical Centre, Sapphire Road, Bishops Cleeve, Cheltenham, Gloucestershire, GL52 7YU

Pharmacy reference: 9011196

Type of pharmacy: Community

Date of inspection: 09/01/2020

Pharmacy context

This is a community pharmacy in a newly opened medical centre in the large village of Bishops Cleeve which is located just to the north of the Cotswold town of Cheltenham. A wide variety of people use the pharmacy. There were many new homes, housing young families, in the immediate vicinity. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It supplies many medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines. It also supplies medicines to the residents of a large local nursing home.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough staff to manage its workload safely. There is evidence that this may have contributed to a recent error.
		2.5	Standard not met	The company has not acted sufficiently to address the concerns raised about staffing levels.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	the pharmacy cannot provide adequate assurance that nursing home services are provided safely. In particular, it does not obtain confirmation from prescribers about any changes or other issues and relies on hand-written notes from the nursing home staff.
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. It is appropriately insured to protect people if things go wrong. The pharmacy keeps the up-to-date records that it must by law. The team members keep people's private information safe and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy was newly opened (August 2019) and located in a newly built health centre. The area had several newly built properties and it was anticipated that both the pharmacy and the health centre would become much busier in the very near future.

The pharmacy team identified and managed most risks. There had been one dispensing error since they had commenced trading. This was a strength error involving diazepam. The item had been self-checked. The pharmacist involved said that the reason that he self-checked the item was that the one dispenser on duty, was busy with another task (see further under principle 2). Near misses were recorded. Some learning points were documented such as identifying 'look alike, sound alike' (LASA) items but there were no specific actions to reduce the likelihood of similar recurrences were recorded.

Coloured baskets only distinguished the prescriptions for patients who were waiting. This meant that it was difficult for the pharmacist to easily prioritise the workload. 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, 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 seen were clear about their roles. A NVQ2 trained dispenser 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. A customer who regularly requested to buy pholcodine cough mixture had been referred to the pharmacist and the sale of this refused.

The staff knew about the complaints procedure and reported that feedback on all concerns was encouraged. They were currently in the process of completing a customer satisfaction survey.

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, private prescription records, emergency supply records, specials records and fridge temperature records were in order. Patient-retuned CDs, seen in the cabinet, had not been entered in the records. This meant that all the fields could not be completed. There were no formal date checking records.

An information governance procedure in place. The pharmacist had 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

collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff seen 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 online.

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

Summary findings

The pharmacy does not have enough staff to manage its workload safely. There is evidence that this may have contributed to a recent error. The company has not acted sufficiently to address the concerns raised about staffing levels. The team members work extra hours in order to keep on top of the workload. The dispenser has no time to complete any on-going learning at work because of the workload pressure. This means that her skills and knowledge may not be up to date.

Inspector's evidence

The pharmacy was in newly opened medical centre (August 2019) in the large village of Bishops Cleeve. They mainly dispensed NHS prescriptions. Many domiciliary patients received their medicines in multi-compartment compliance aids. The pharmacy had recently started to deliver services to the residents of a large nursing home.

The current staffing profile was one pharmacist, the manager and one NVQ2 qualified dispenser. This meant that both staff members were often interrupted with their work in order to serve customers. This increased the likelihood of errors. And, there was evidence to support that staffing levels may have contributed to a recent error (see under principle 1). The pharmacist regularly came in early and often left late in order to keep on top of the work. She said that she had repeatedly asked for extra help. Some extra help had been provided in October, November and December 2019. But, she did not know ahead when this would be and so was unable to effectively plan the workload, especially that relating to the compliance aids and the nursing home.

The pharmacy needed to assemble the medicines for the large nursing home the week following the visit. At the time of the visit, the pharmacist did not know if she was going to receive any extra help in order to get these delivered in time.

The staff had an annual performance appraisal where any learning needs could be identified. The dispenser said that she was supported by her immediate manager. But, she had no time to complete any on-going learning at work. She did this at home. The pharmacist said that all learning was documented on her continuing professional development (CPD) record. She said that she was not pressured to do Medicines Use Reviews but that the current staffing levels made it difficult to do these because of the time needed, in the consultation room, away from the dispensary, to complete them. She did however do several New Medicine Service (NMS) reviews because these could be done in the dispensary and she did as many MURs as she could.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally appears professional but the design and layout of the premises may prove challenging in the event of the anticipated growth in its workload. The pharmacy signposts its consultation room, on the door, but, this is not visible when people enter the pharmacy. So, people may not be aware that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy appeared to be spacious and well laid out but best use of the space had not been made. There was little working bench space and the pharmacy had recently started providing services to a large local nursing home. In addition, these medicines were racked which required additional space. There were no separate, dedicated areas for the assembly and checking of these medicines. Similarly, the pharmacy assembled many compliance aids, also with no separate, dedicated areas for these. There was only one assembly bench and one checking bench for all prescriptions. The pharmacy was located in a newly built medical centre. There were many new homes in the close vicinity and a high possibility that both the pharmacy and the surgery will become much busier in the very near future.

A large amount of space was allocated to the retail area. 'Pharmacy only' (P) medicines were located a long way behind the medicine till. This meant that there was a lot of unused empty space between the till and the shelving. And, a disproportionate amount of shelving was allocated to the storage of the 'P' medicines.

The premises were clean. But, parts of the dispensary were unfinished and still contained the written measurements and construction markings made by the fitters. Finishing trims appeared to be missing. And, a table in the retail area had the remnants of cellotape. These did not present a professional pharmacy image.

The consultation room was spacious and well signposted on the door. But, the signposting was not visible to people as they entered the pharmacy. The room contained a computer and a sink. 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.

The temperature in the pharmacy was below 25 degrees Celsius. There was no air conditioning, despite it being a new build. There was good lighting throughout. Most items for sale were healthcare related.

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

Summary findings

The pharmacy cannot provide adequate assurance that the nursing home services are provided safely. In particular, it does not obtain confirmation from prescribers about any changes or other issues, it relies on hand-written notes from the nursing home staff and it does not send the prescriptions to the home for checking. The pharmacy generally manages the rest of its services effectively to make sure that they are delivered safely. It mainly gets its medicines from reliable sources and the medicines are stored safely. People can access the services that the pharmacy offers. The pharmacy team members make sure that people only get medicines or devices that are safe but there could be a better audit trail demonstrating that this is the case.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with an automatic opening front door. There was access to the NHS telephone translation service and to 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), emergency hormonal contraception (EHC), the Community Pharmacy Consultation Service (CPCS) and seasonal flu vaccinations. The latter was also provided under a private scheme as was malaria prophylaxis. 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 suitable training for the provision of the free NHS EHC service. The pharmacist consulted the 'fit for travel' website prior to providing prophylactic treatment for malaria.

A large amount of the current workload at the pharmacy was the assembly of medicines into compliance aids for a large number of domiciliary patients and the assembly of medicines for the residents of a large nursing home. As mentioned in principle 3, there was little bench space for these services and, as mentioned in principle 2, insufficient staff to easily perform these tasks. The staff worked extra hours to keep on top of the workload and to their credit, they were not behind their work schedule for the compliance aids. But, the medicines for the nursing home were due in just over a week. At the time of the visit, they had yet not started the assembly of these. And, the timescale made it difficult to deal with any changes or missing items on time. In addition, as mentioned in principle 2, the staff did not know if they were going to get extra help to ensure that the medicines went out on time.

The domiciliary compliance aids were assembled on a four-week rolling basis and evenly distributed throughout the week to try to manage the workload as best as possible. Past changes were not recorded and so the checking pharmacist did not have a clear clinical picture of the patient. The pharmacist said that she would address this. The assembled compliance aids were stored tidily on dedicated shelves.

The pharmacy had only recently taken on the provision of services to a large local nursing home. The

pharmacy ordered the prescriptions from a list provided by the home. Several hand-written requests were seen, including one for the high-risk item, rivaroxaban 15mg and also items were seen to be annotated with 'please remove'. The surgeries that served the patients in the home did not give any written or verbal confirmation to the pharmacy about these changes. And, the pharmacy was responsible for chasing any perceived missing items or other issues. The pharmacy did not send copies of the prescriptions to the home for checking. Neither the pharmacist nor the dispenser had any experience or training in the provision of services to care homes. They did not use a communication diary to record any issues but the pharmacist would call the home if she had any concerns. The pharmacy staff were not sure about the training that the nursing home staff received. They did not know if anyone did regular medicine management visits but believed that the superintendent would visit the home. The pharmacy was responsible for ensuring that all patients who had their medicines in compliance aids and also those residents of the nursing home who were prescribed high-risk drugs, were having the required blood tests.

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. The pharmacist counselled patients prescribed clarithromycin and were also prescribed a regular statin. She also counselled patients prescribed oral steroids. The staff were aware of the sodium valproate guidance relating to the pregnancy protection program. One 'at risk' patient had been identified and appropriately counselled. Guidance leaflets were included with all prescriptions 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 all medicines. The delivery driver said that he only got signatures from patients or their carers in about 20% of cases. Owing slips were used for any items owed to patients. The pharmacist said that whilst the staff levels made doing MURs difficult, she did try to do as many as possible. She had identified issues, such as, patients taking their levothyroxine with their breakfast. She gave them advice about taking this before food with water and not with anything containing calcium.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, Phoenix and Badhams Warehouse. The latter sent the pharmacy unlicenced medicines such as thiamine 100mg and vitamin B compound strong. These were seen on the dispensary shelves. Specials were obtained from Lexon Specials. 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 some patient-returned CDs (not entered in the records, see in principle 1). 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 said to be in place but there were no formal records to verify this. Designated bins were available for medicine waste and used. There was no separate bin for cytotoxic and cytostatic substances or the list of such substances that should be treated as hazardous for waste purposes. The list was printed off during the inspection. The staff said that they would appropriately separate any such substances until they obtained a dedicated bin.

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 but any actions were not recorded. The pharmacy had received an alert on 5 December 2019 about ranitidine tablets. The pharmacy had none in stock but this was not recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services it provides. And, the team members make sure that it is 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 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 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.