General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Badham Pharmacy Ltd, Wilson Health Centre, 236 Prestbury Road, Cheltenham, Gloucestershire, GL52 3EY

Pharmacy reference: 9011904

Type of pharmacy: Community

Date of inspection: 13/02/2024

Pharmacy context

This is a community pharmacy in a residential area of Cheltenham, Gloucestershire. The pharmacy is in a Health Centre which also has two GP surgeries. The pharmacy dispenses NHS and private prescriptions, sells a few over-the-counter medicines, and provides health advice. It also offers the New Medicine Service (NMS), local deliveries, blood pressure checks and the Pharmacy First scheme. In addition, its team members provide multi-compartment compliance packs for people who find it difficult to manage their medicines at home as well as supplying medicines to a residential care home. The pharmacy also operates a collection point where people can collect their medicines outside of the pharmacy's opening hours.

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	1.2	Good practice	The pharmacy ensures that the safety and quality of its services are regularly reviewed and monitored. Team members routinely record, review, and seek to learn from as well as minimise mistakes recurring.
		1.8	Good practice	The pharmacy's team members actively ensure the welfare of vulnerable people. The pharmacy can demonstrate that it has taken appropriate action in relation to concerns identified, the relevant processes are in place to assist with this and team members are suitably trained.
2. Staff	Standards not all met	2.2	Good practice	Members of the pharmacy team have the appropriate skills, qualifications and competence for their role and the tasks they undertake. The regular responsible pharmacist (RP) actively goes above and beyond to ensure a seamless service is provided.
		2.5	Standard not met	Members of the pharmacy team are inadequately supported, and under-resourced. There is limited evidence that sufficient action has been taken when team members have raised legitimate concerns about the lack of staff.
3. Premises	Standards met	3.5	Good practice	The pharmacy premises have been designed and laid out well. The pharmacy has modern fixtures and fittings. The premises are professional in appearance with ample space available to ensure pharmacy services are provided appropriately.
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy's services are provided appropriately using verifiable processes. The pharmacy's team members have incorporated safe practice for people prescribed higher-risk medicines into their working routine. The pharmacy's services are delivered safely using verifiable processes. Members of the pharmacy team are promoting safe practice for people

Principle	Principle finding	Exception standard reference	Notable practice	Why
				requiring additional services and for those prescribed higher-risk medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has safe and effective procedures in place. It has suitable systems to identify and manage the risks associated with its services. Members of the pharmacy team monitor the safety of their services by recording their mistakes and learning from them. They actively protect the welfare of vulnerable people. The pharmacy safeguards people's private information appropriately. And it generally maintains its records as it should.

Inspector's evidence

The pharmacy was efficiently run. It was clean and tidy, with clear benches in the dispensary, organised processes in place and capable members of staff. People were observed to be served promptly. However, footfall and prescription numbers were high due to the pharmacy's location, and additional workload from preparing multi-compartment compliance packs. This was therefore a busy pharmacy. The current staffing levels in comparison to the pharmacy's volume of workload were stretched and had at times been minimal (see Principle 2).

The pharmacy had current documented and electronic standard operating procedures (SOPs) which provided the team with guidance on how to carry out tasks correctly. The staff had read them with a new member of staff due to do so (see Principle 2). Members of the pharmacy team understood their roles well and worked in accordance with the company's set procedures. Team members had set tasks, but readily helped where needed to efficiently manage the workload. Staff were observed to work independently of the responsible pharmacist (RP) in separate areas of the pharmacy. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

The pharmacy had suitable internal processes and systems to identify and manage risks associated with its services. The dispensary had designated areas for different processes to take place. This included a section for people who required multi-compartment compliance packs, labelling and the preparation of prescriptions, assembled prescriptions requiring delivery, owed medicines and a section for the pharmacist to undertake the final accuracy-check of assembled prescriptions.

The teams near miss mistakes were routinely recorded by the RP. The details were collated and reviewed formally every month which helped identify any trends or patterns. Remedial activity was then undertaken to help minimise mistakes. The documented information seen also helped demonstrate this. Staff explained that certain medicines were separated and highlighted to help reduce the likelihood of mistakes happening. This included those that looked-alike and sounded-alike such as different strength of prednisolone and hydroxychloroquine and hydroxycarbamide. Mistakes had frequently occurred with certain eye drops, so their storage had been rearranged and higher-risk medicines were highlighted. The RP's process to handle incidents was suitable and in line with requirements, it involved appropriate handling of the situation, formal reporting, and investigation to identify the root cause. The necessary changes were then implemented in-house.

Staff had been trained to safeguard the welfare of vulnerable people. The pharmacist had been trained to level two through the Centre for Pharmacy Postgraduate Education (CPPE). Team members could recognise signs of concerns; they knew who to refer to in the event of a concern and described concerns seen as well as how they had responded. Contact details for the local safeguarding agencies were also easily accessible.

The pharmacy's team members had been trained to protect people's confidential information. The team ensured confidential information was protected as no sensitive details were left in the retail area or could be seen from the retail space. Bagged prescriptions awaiting collection were stored in a location where personal information was not easily visible. Confidential information was stored and disposed of appropriately. Computer systems were password protected and staff used their own NHS smart cards to access electronic prescriptions.

The pharmacy's records were mostly compliant with statutory and best practice requirements. This included a sample of registers seen for controlled drugs (CDs). On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. The pharmacy had suitable professional indemnity insurance arrangements in place. Records about emergency supplies and records verifying that fridge temperatures had remained within the required range had been appropriately completed. However, incomplete details about prescribers had been documented within the electronic private prescription register and there were some gaps within the RP record. The former had already been identified and team members were in the process of amending this.

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

Summary findings

The pharmacy frequently has insufficient staff to manage its workload safely, even if overall it may appear to have enough. Members of the pharmacy team struggle to keep up with their workload. They are working under pressure and considerable stress because the pharmacy does not provide them with contingency or additional support when this is needed. But members of the pharmacy team are suitably qualified for their roles. The company provides them with resources so that they can complete regular and ongoing training. This keeps their skills and knowledge up to date.

Inspector's evidence

On the day of the inspection, the pharmacy had an adequate number of staff to manage its workload. However, this was not always the case (see below) and in line with the volume of work undertaken, more staff were needed. Consequently, the team was not always up to date with the workload and often struggled to keep up to date with routine tasks or finish work on time.

Team members present included the regular RP and manager, two trained dispensers and two medicines counter assistants, one of whom was very newly employed and full-time. The other MCA and both dispensing assistants worked four days a week. All staff were fully trained through accredited routes. The team's certificates of qualifications obtained were not seen but their competence was demonstrated. The pharmacy's team members worked well together. They knew which activities could take place in the absence of the RP and referred appropriately. Relevant questions were asked before selling medicines. As they were a small team, meetings and discussions took place regularly. Formal performance reviews had taken place and the staff were provided with resources for ongoing training. This helped ensure they continually learnt and kept their knowledge up to date.

Staff stated that they liked working at the pharmacy. But they also expressed dissatisfaction and frustration with the lack of staff (see below), lack of investment in the team and the conditions under which they had to work. The pharmacy was considerably busy with walk-in as well as repeat prescriptions and assembling medicines for people in the care homes or inside multi-compartment compliance packs. The pharmacy's volume of work meant that the team was stretched and at times there had not been enough staff to safely support and prepare people's medicines easily. This included no contingency cover for sickness or cover for staff holidays. During very busy periods such as in December and the run-up to Christmas, there had just been one dispenser and the RP.

Staff explained that they had previously been significantly behind with the workload. Medicines for compliance packs were being prepared the day before they were due and then checked for accuracy by the pharmacist on the day that they needed delivering. This practice significantly increases the chance of mistakes occurring. The team did not always have time to complete other tasks required. This included making and entering records for CDs supplied within the required time frames. The RP always worked through lunch, after closing until 7pm and on her day off (Saturdays) to try and catch up. This had affected her personal life. Working like this was described as stressful and pressurised.

The inspector was informed that the lack of staff had been frequently highlighted to the superintendent pharmacist (SI), and more staff requested, with assistance only provided on one occasion recently. Certain personnel in the company's HR department were said to have hung up on the RP or team members when they had expressed concerns and required more staff. The inspector was told that the

SI did not listen. He had turned up once when there had been one MCA and one dispenser working alongside the RP and had said to the team that they had enough staff and what were they complaining about. Only the operations director for the company was said to have been kind, listened to the team's concerns and tried to help where he could.

There were also additional pressures being put on the team to undertake services such as the Pharmacy First scheme (see Principle 4). The RP described feeling overwhelmed with the way the service had been commissioned and rolled out in the pharmacy. The RP was told to deliver the service as soon as the Patient Group Directions were provided with no additional help or training provided. She described reading the relevant paperwork and processes in bed at night because no other time had been provided to do this. The pharmacy initially, was also not given the necessary equipment which meant that the RP had to use her mobile phone as a torch after gaining people's consent to do this. Staff therefore did not feel comfortable or supported enough to offer this service. The RP has since informed the superintendent that patient safety come first. The service will only be provided if she has the time to do this.

Following the inspection, the SI provided the inspector with the staff rota for December 2023 and stated that the pharmacy had been supported with one of the directors. He reiterated the recent support described above, and said that there had only been one occasion where the pharmacy had operated with just the RP and one dispenser. This was a Saturday morning. The SI also explained that the company was geared to support all the pharmacies it owned through its HR team and a monthly dispensary shift sheet to plan future holiday requirements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises provide a suitable environment for people to receive healthcare services. The pharmacy is kept clean, it is secure, designed well and professionally presented. And it has a separate space where confidential conversations or services can take place.

Inspector's evidence

The pharmacy premises were new and had been designed to a high specification. The pharmacy premises included a retail area with two entry points, two consultation rooms, dispensary, and staff areas to one side. The dispensary was very spacious with ample space to carry out dispensing tasks safely. There were designated sections for various activities to take place and for storage. Every area was well signposted and kept clear of clutter. The consultation rooms were also spacious, only one was being used for private conversations and services. The other held excess stock and waste to be disposed of. The room was signposted, kept locked when not in use and it was appropriate for its intended purpose. The pharmacy was clean and tidy. The premises were bright, suitably ventilated, and professional in appearance. The ambient temperature was suitable for the storage of medicines. The pharmacy was secured against unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s working practices are safe and effective. People can easily access the pharmacy’s services and the pharmacy provides useful services. Team members identify people with higher-risk medicines so that they can provide the appropriate advice. This helps ensure they take their medicines correctly. The pharmacy sources its medicines from reputable suppliers. It stores and manages its medicines well.

Inspector's evidence

The pharmacy's opening hours were on display alongside some information and leaflets to promote health or services. People could enter the pharmacy through two ways. The first was through the health centre and the second via the front door. This was wide and accessible from a ramp outside. The retail area consisted of clear, open space and wide aisles. This helped people with restricted mobility or using wheelchairs to easily access the pharmacy's services. There were four chairs inside the pharmacy if people wanted to wait for their prescriptions and a car park available outside. Staff could make suitable adjustments for people with diverse needs, they would use simple language to aid people when required. They also described speaking slowly and clearly to help people to lip read and written communication was used for people who were deaf or partially deaf. Team members were aware of the local health facilities to signpost people accordingly if this was required. They also had access to documented information to assist with this.

The pharmacy also provided an automated collection point. Dispensed prescriptions were stored inside and could be collected from a vending machine. This could be accessed by people 24 hours a day and on seven days of the week. The machine was located to one side of the premises, with the internal section accessible from one end of the retail area. This section was kept locked and the unit itself was shuttered and alarmed. The pharmacy had deregistered the area in which the vending machine was situated, so that a RP and their supervision was not required. This meant that the vending machine could then operate outside the pharmacy's opening hours. The pharmacy had obtained written consent from people to sign up to the service and there was an SOP to provide guidance to the team. Prescriptions for CDs, fridge and bulky items were not included as part of the service. The RP described calling people beforehand if counselling was required. This included prescriptions with higher-risk medicines or where pharmacist intervention was required.

The pharmacist had begun providing the recently commissioned Advanced NHS service – Pharmacy First scheme. She had read through the service specification and patient group directions (PGDs) to help familiarise herself with the processes and criteria. The RP already knew how to use the otoscope but described being booked onto training for this service on the 18th of this month, this was to be delivered through the Local Pharmaceutical Committee. A few people had received medication for certain conditions such as for a sore throat and impetigo. Suitable equipment was present which helped ensure that the service was provided safely and effectively (see Principle 5). The service specification and PGDs to authorise this were readily accessible and had been signed by the RP. Whilst this scheme was described as useful for people, there were disadvantages noted for the pharmacy team. This included the time taken to complete the necessary paperwork and issues from a lack of understanding by the surgery staff. The latter had begun sending every person to the pharmacy who requested an appointment with them without realising what the service involved. The RP had fed back to them that

she could not filter every one of their patients in this way.

The superintendent pharmacist was said to provide the NMS and the pharmacy also provided a blood pressure (BP) service. This was led by the RP but also support staff. Team members had been appropriately trained before taking people's BP. The RP explained that people with undetected high blood pressure had been seen. They were referred to the GP surgery which had resulted in prescribed medication being required.

The workflow involved prescriptions being prepared by staff in designated areas and the RP checked medicines for accuracy from a separate area. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. The baskets were also colour-coded to highlight priority and different types of prescriptions. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process. Team members routinely used these as an audit trail.

People's medicines were delivered to them, and the team kept records about this service. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and in general, no medicines were left unattended. People occasionally requested for the latter to take place, staff made appropriate checks, documented details and could justify this practice when it had been required.

The pharmacy also supplied some people's medicines inside compliance packs once the person's GP or the team had identified a need for this. The pharmacy ordered prescriptions on behalf of people for this service and specific records were kept for this purpose. Any queries were checked with the prescriber and the records were updated accordingly. All medicines were removed from their packaging before being placed inside them. Descriptions of the medicines inside the compliance packs were provided and patient information leaflets (PILs) were routinely supplied.

The pharmacy provided medicines as original packs to residents in one care home. The care home ordered repeat prescriptions for their residents, and both the pharmacy and care home staff used an electronic medicines administration record (eMAR) system. This was said to be beneficial in the way it worked for care home staff but very time consuming for pharmacy staff. Any changes or missing items were monitored, and records were maintained to verify this. Staff obtained information about allergies and recorded the details. None of the residents required higher-risk medicines. Interim or medicines which were needed mid-cycle were dispensed at the pharmacy.

The team routinely identified people prescribed higher-risk medicines. On handing-out assembled prescriptions, staff asked details about relevant parameters, such as blood test results for people prescribed these medicines. After obtaining this information, records were kept about this. Team members were also aware of risks associated with valproates. Staff ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them, and had identified people at risk, who had been supplied this medicine. People were counselled accordingly.

The pharmacy's stock was largely stored in an organised way. Licensed wholesalers were used to obtain medicines and medical devices. The team date-checked medicines for expiry regularly and kept records of when this had happened. Short-dated medicines were routinely identified. There were no date-expired medicines or mixed batches present. CDs were stored under safe custody. Medicines were kept appropriately in the fridge. Dispensed medicines requiring refrigeration were stored within clear bags. This helped to easily identify the contents upon hand-out. Medicines returned for disposal, were accepted by staff, and stored within designated containers. This included sharps. Drug alerts were

received electronically and actioned appropriately. Records were kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. Its equipment is clean. And the team ensures they are used appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy's equipment and facilities were suitable for their intended purpose. This included access to suitable reference sources, a range of clean, standardised conical measures for liquid medicines, counting triangles, a legally compliant CD cabinet and appropriately operating pharmacy fridges. The dispensary sink for reconstituting medicines was clean. The pharmacy had hot and cold running water available. The blood pressure machine was new. Relevant equipment for the Pharmacy First scheme had also recently arrived. This included an otoscope, pulse oximeter, thermometer, and torch for example. Computer terminals were positioned in a location that prevented unauthorised access. The pharmacy had cordless telephones so that private conversations could take place if required and confidential waste was suitably disposed of.

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.