General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Borno Chemists Ltd., Colne House, 96 Mount Chambers, Coggeshall Road, BRAINTREE, Essex, CM7 9BY

Pharmacy reference: 1030944

Type of pharmacy: Community

Date of inspection: 05/10/2022

Pharmacy context

The pharmacy is located near Braintree town centre in a largely residential area. It receives most of its prescriptions electronically. And it provides a range of services, including the New Medicine Service, flu vaccination service and blood pressure checks. The pharmacy supplies medications in multi-compartment compliance packs to a large number some people who live in their own homes to help them manage their medicines. And it also provides medicines as part of the Community Pharmacist Consultation Service.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. The pharmacy provides people with information about how they can complain about its services. It protects people's personal information. Team members understand their role in protecting vulnerable people. And the pharmacy largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. It had documented, up-to-date standard operating procedures (SOPs), and reviewed dispensing mistakes. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed with team members. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Different strengths of clonazepam tablets had been separated as the packaging looked very similar. The pharmacist said that there had not been any recent dispensing errors, where a dispensing mistake had reached a person. Dispensing errors were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that the pharmacy's head office would be informed.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription. And team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. Team members explained that the pharmacy would remain closed if the pharmacist had not turned up in the morning. They knew which tasks they could and should not undertake if there was no responsible pharmacist (RP) signed in or if the RP was absent from the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The private prescription records were mostly completed correctly, but the prescriber's details were not always recorded and those which were recorded were not always correct. This could make it harder for the pharmacy to find these details if there was a future query. The pharmacist explained that the pharmacy would make a record on the pharmacy's computer system if a supply of a prescription-only medicine was supplied in an emergency without a prescription. But he said that people were usually referred to their GP for a prescription if they had run out of their medication. The pharmacy had not made any recent emergency supplies as the pharmacy was open at the same time as the local GP surgery. The right RP notice was clearly displayed and the RP record was largely completed correctly. But there were occasions where the pharmacist had not completed the record at the end of their shift and a different pharmacist was RP the following day. The pharmacist said that he would ensure that it was completed correctly in the future. Controlled drug (CD) registers examined were largely filled in correctly, and the CD running

balances were checked at regular intervals. One of the balances in the CD register was not correct. The pharmacy had been making multiple entries on one line in the register and this had meant that the calculations were not always correct. The pharmacist said that he would review this process to make it easier to notice errors. And he would report any unresolved discrepancies to the Controlled Drugs Accountable Officer promptly.

The pharmacy's computers were password protected and the people using the pharmacy could not see information on the computer screens. And confidential waste was removed by a specialist waste contractor. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy had carried out patient satisfaction surveys in the past, but it had not carried one out since the start of the pandemic. The pharmacist said that he would attempt to address any complaints and would refer to the pharmacy's head office if needed. The complaints procedure was available for team members to follow. Details about how people could complain were displayed at the medicines counter, and they were available on the pharmacy's website.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy's head office. One of the dispensers described who might be classed as a vulnerable person and said that she would refer any concerns to the pharmacist. There had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, two trained dispensers (one was the branch co-ordinator), one trainee dispenser and one trained medicines counter assistant (MCA) working during the inspection. There was also a person who was working in the back office who was responsible for managing the stock, including ordering, and putting away. The pharmacist said that the stock controller had worked at this pharmacy for around two or three months but he had worked within the company prior to that. The pharmacist was unsure what training the stock controller had undertaken prior to starting at the pharmacy. He said that he would check with the pharmacy's head office to ensure that the stock controller was enrolled on an appropriate course within he required timeframe. Team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And they wore smart uniform with name badges.

The MCA appeared confident when speaking with people. And she used effective questioning techniques to establish whether the medicines were suitable for the person. She was aware of the restrictions on sales of medicines containing pseudoephedrine. And said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care.

The branch co-ordinator managed the team's training. Team members regularly completed online training modules from the pharmacy's head office. And they were allowed time during the day to undertake any necessary training during quieter times. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And he said that he felt able to take professional decisions. He said that he had recently completed some online training about chronic obstructive pulmonary disease.

The team had yearly appraisals and performance reviews. They said that they felt comfortable about discussing any issues with the pharmacist or making any suggestions. Most team members had worked at the pharmacy for several years and they said that they would openly discuss any issues as they arose and change things where needed to improve working practices. And they also had regular reviews of any dispensing mistakes and discussed these openly in the team. The branch co-ordinator said that they had a monthly meeting with a representative from head office to discuss any issues, including any maintenance problems. Targets were set for the New Medicine Service. The branch co-ordinator said that the pharmacy usually met its target. And the service was carried out for the benefit of people using the pharmacy. The team said that they would not let the target affect their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was bright, clean, and tidy throughout which presented a professional image. And it was secured from unauthorised access. Air conditioning was available and the room temperature was suitable for storing medicines. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. And pharmacy-only medicines were kept behind the counter.

There were four chairs in the shop area and all had arms to aid standing. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was to the rear of the pharmacy. People wanting to use the room had to pass by the side of the medicines counter. It was small but suitably equipped and well-screened. And it was accessible to wheelchair users. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. And overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. But the pharmacy doesn't highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was a ramp up to the main entrance with a small step at the top. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy could produce large-print labels for those people who needed them.

Prescriptions for higher-risk medicines were not highlighted. And the pharmacist said that he did not routinely speak with people taking higher-risk medicines such as methotrexate and warfarin. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that he would highlight prescriptions for these medicines in future and speak with people to ensure that they were taking their medicines safely. Prescriptions for Schedule 3 and 4 CDs were not highlighted. And one member of the team was unsure which prescriptions were only valid for 28 days. The pharmacist said that he would ensure that prescriptions which were only valid for 28 days were highlighted in future to help minimise the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. Team members were not aware that the warning cards could be removed from the original packaging to allow room to attach the dispensing label. And the pharmacy did not have additional warning cards and warning stickers available. The pharmacist was aware of the current guidance about pregnancy prevention for people taking valproate-containing medicines. He said that he would request the additional warning cards and stickers from the manufacturer and he would ensure that these were provided when these medicines were supplied.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next several months were marked. But there were a few items found with dispensing stock which had expired in July 2022. The dispenser said that the items might have arrived at the pharmacy already out of date and she would ask the stock controller to check this. A box containing mixed batches was found with dispensing stock. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The team said that they would ensure that medicines were kept in their original packaging in future.

Fridge temperatures were checked daily and the maximum and minimum temperatures were recorded. Records indicated that the temperatures were largely within the recommended range. There were two occasions recently where the temperature of one of the fridges had reached 8.4 degrees Celsius. The

dispenser said that the fridge door would sometimes not close properly, but the alarm would sound to alert staff. But there was no record to show that the temperature had been rechecked and the thermometer reset. The dispenser said that she would ensure that any anomalies were recorded in future to help identify how long the temperature had been out of the recommended range. She explained that the pharmacy's head office was informed about any cold chain breaches.

Part-dispensed prescriptions were checked frequently and they were kept at the pharmacy until the remainder of the medication was dispensed and supplied. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. The MCA said that people were sent an automated text message when their items had been dispensed. Uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items after around one month. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

One of the dispensers said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. One of the dispensers explained how people would contact the pharmacy if they did not need their 'when required' medicines when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. There were no completed packs available for the inspector to check on the day of the inspection. One of the dispensers explained how the packs were assembled and labelled, and how the backing sheets were attached to the packs. She said that there was an audit trail to show who had dispensed and checked each pack. And medication descriptions were put on the packs to help people and their carers identify the medicines. The dispenser said that the medicine information leaflets were not routinely supplied. And these would usually only be supplied when a person was started on a medication. This could make it harder for people to have up-to-date information about how to take their medicines safely. The dispenser said that she would ensure that these were supplied in future.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery. The delivery driver said that he would possibly be making his deliveries for around five hours before returning to the pharmacy and he did not attempt to deliver fridge items first. The pharmacist said that he would speak with the pharmacy's head office to enquire about a cool box. One of the dispensers said that the previous delivery driver used to use one to keep fridge items cool.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. One of the dispensers explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

The pharmacy’s equipment for measuring liquids and triangle tablets were clean. A separate counter was marked for cytotoxic use only and this helped avoid cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around one year. The pharmacist said that it would be replaced in line with the manufacturer’s recommendations. The phones in the dispensary were portable so they could be taken to a more private area where needed. The fridges were suitable for storing medicines and was not overstocked.

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.