General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Borno Pharmacy, 10 Great Square, BRAINTREE, Essex, CM7 1UA

Pharmacy reference: 1030945

Type of pharmacy: Community

Date of inspection: 19/09/2019

Pharmacy context

The pharmacy is in the town centre of Braintree in Essex. It is in a listed building and about to undergo a major refitting programme to bring the premises up to current standards. The pharmacy dispenses NHS prescriptions. And it provides Medicines Use Reviews (MURs) and occasional New Medicine Service (NMS) consultations. A small number of people use the substance misuse service. The pharmacy assembles medication into multi-compartment compliance packs for some people who need help managing their medicines. It delivers medicines to people in their homes on four days a week. People can ask to have their blood pressure tested. The pharmacy administers flu vaccinations during the winter season. It plans to reintroduce Health-Checks and smoking cessation once team members have completed training.

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 identifies and manages the risks associated with its services. It records and regularly reviews its mistakes and can show how the team learns and improves from these events. Its team members have clear roles and responsibilities and it asks the people who use the pharmacy for feedback. Team members know how to protect vulnerable people. And they generally keep people's personal information safe. The pharmacy largely keeps the records it needs to by law but does not always record the reason that a medicine is supplied in an emergency. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query.

Inspector's evidence

The pharmacy kept near miss and error logs and these were reviewed monthly to identify any trends or patterns. Following dispensing incidents, the mistake was discussed with the individual concerned on a one-to-one basis, with any learnings shared with the dispensary team. The team members used stickers to highlight medicines at a higher risk of mistakes. They identified that most mistakes happened when the pharmacy was busiest, and they said that they had made the conscious decision to take additional time to prepare medicines and to mark the dispensed boxes, especially when the pharmacy was busy. The trainee dispenser had started to take additional mental breaks as she had been working extended shifts. Team members were sometimes encouraged to identify their own errors and were comfortable about feeding back to the pharmacist. They talked about a culture in the pharmacy where mistakes were discussed to reduce future risk.

People were asked to complete an annual satisfaction survey and the pharmacy had scored an 80% overall rating on their most recent result. There were several positive comments about the friendliness of the pharmacy team. The pharmacy had current professional indemnity insurance.

The pharmacy had the right responsible pharmacist (RP) notice on display and RP records were generally completed correct, but the pharmacist did not always sign out at the end of the day. This could make it harder to identify who was responsible for the pharmacy services. Roles and responsibilities were identified in the standard operating procedures (SOPs). When asked, members of the pharmacy team clearly understood what they could and couldn't do when the pharmacist was not present.

The pharmacy had a comprehensive range of online SOPs which covered, for example, dispensing processes, information governance, controlled drugs (CDs), RP activities, sale of medicines, high-risk medicines, dispensing incidents and services the pharmacy provided. The superintendent checked that members of staff had read and agreed SOPs relevant to their roles. There were online knowledge checks to ensure that team members understood the SOPs

The records examined were generally maintained in accordance with legal and professional requirements. These included: the electronic private prescription register and records for the supplies of unlicensed medicines. But, the reason for an emergency supply was not always recorded. There was also a book where patient returned CDs were recorded. CD running balances were checked routinely.

The pharmacy had a cordless phone to facilitate private conversations and the correct NHS smartcards

were in use. The patient medication record (PMR) was password protected and sensitive waste was securely disposed of. Prescriptions were stored securely in the dispensary. The pharmacy team had undertaken training about the General Data Protection Regulation and had signed confidentiality agreements. Several dispensed prescriptions could be seen by people standing at the pharmacy counter. During the inspection, the pharmacist arranged for a wooden panel to be installed to block the view to the relevant shelf. The pharmacy had safeguarding procedures and team members described the actions that would be taken in the event of a safeguarding concern. There were contact details available for the local safeguarding team.

Principle 2 - Staffing ✔ Standards met

Summary findings

Currently, the pharmacy has just enough team members to manage its workload safely. And it has recruited new team members to further help with the workload. Team members are appropriately trained and have a good understanding about their roles and responsibilities. They make suggestions to improve safety and workflows where appropriate. They are provided with feedback and have appraisals to identify any opportunities for development or learning.

Inspector's evidence

The regular pharmacist had recently left, and the pharmacy was largely operating using locum pharmacists. There was one part-time trained dispenser and one part-time trainee dispenser. A new full-time dispenser was due to join the team in the coming weeks. There was a new Medicines Counter Assistant who was also due to start working in the pharmacy. The trainee dispenser had been working additional hours each week to make sure that the pharmacy was able to keep up-to-date with routine tasks. The pharmacy was generally up to date with the prescriptions and routine tasks.

Team members used an e-learning portal to complete training which helped them to keep their knowledge and skills up to date. This was tracked and operated through head office. Team members said that the use of this had been limited over the last few months as the staffing levels had been less than ideal, but there were plans to change this with the new staff members starting. Examples of training completed included safeguarding, dementia awareness, data protection and a range of topics related to seasonal medicines and new products. They also reviewed their SOPs using this tool.

All the staff had annual appraisals which looked at areas where the staff were performing well and areas for improvement or opportunities to develop. A team member said that they felt empowered to make suggestions and changes and the two members of the dispensary team had started a new procedure for the multi-compartment compliance packs. This included arranging people’s packs into designated assembly weeks, using reminder charts and coloured baskets to improve the improve the efficiency of the service and to make sure that people’s medicines were available when they needed them. Targets and incentives were in place, but the pharmacist said that these did not impact on patient safety or professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy team keeps the pharmacy secure. People can have a conversation with a team member in a private area. Whilst the pharmacy is currently adequate for the services it is providing, it is in a less than ideal state of repair. But refit works have already commenced to bring the premises up to a modern standard. Some of this is reliant on planning consent.

Inspector's evidence

The pharmacy had vinyl floors throughout, laminated worktops and a dedicated sink for the preparation of medicines. These were generally clean, but the dispensary was small and crowded for the volume of prescriptions with some trays of medicine on the floor. Some of the shop fittings such as the pharmacy counter had been repaired with tape which looked unsightly. There was an upstairs room which was used to assemble multi-compartment compliance packs and a cellar which was in the process of being completely refitted and renovated to provide a designated area for assembling the packs which was fit-for-purpose. The planned refit works included, enlarging the dispensary and bringing the premises up to a modern standard.

There were workflows in place and a designated checking area which was largely kept tidy to reduce the risk of mistakes. The pharmacy had appropriate levels of lighting throughout. The room temperature in the room used for compliance packs was not monitored and a team member said that it was very cold in the winter and uncomfortably hot in the summer. They said that they would obtain a maximum and minimum thermometer to make sure that the room was kept at an appropriate temperature to store medicines.

There were two clean, bright and appropriately-maintained consultation rooms with hand washing facilities and a reasonable level of soundproofing where people could consult pharmacy team members in private. The room containing a computer was kept locked when not in use. The pharmacy premises were kept secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and effectively. It gets its medicines from reputable suppliers and stores them properly. Its team members identify and give advice to people taking higher-risk medicines to make sure that they are taken safely. And team members take the right action if any medicines or devices need to be returned to the suppliers. This means that people get medicines and devices that are safe to use.

Inspector's evidence

The pharmacy was accessed via a wide door at path level and there was an open layout to assist wheelchair users. Team members had trained as Dementia Friends.

The pharmacy obtained dispensing stock from a range of licenced wholesalers and it was stored in a neat and tidy manner in the dispensary. A team member said that stock was date checked quarterly but could not locate the records to support this. No expired products were found on the shelves. The pharmacy staff were aware of the Falsified Medicines Directive but did not yet have the scanners in place to allow them to deactivate medicines on the appropriate database.

The pharmacy counselled people on higher-risk medicines such as lithium, warfarin and methotrexate and the pharmacists routinely enquired about whether they were having blood test related to these medicines. They also provided additional advice to people about how to take these medicines safely. Results from people's blood tests were routinely recorded on the patient's medication record (PMR). But, the pharmacy team members were not aware of the risks associated with dispensing valproate containing products, or the Pregnancy Prevention Programme. The inspector discussed this with the team members during the inspection. The published support materials could not be located in the pharmacy and the pharmacist agreed to order them as a matter of priority.

The pharmacy kept medicines requiring cold storage in a pharmaceutical fridge. The maximum and minimum temperatures were continually monitored and recorded daily. The records suggested that stock was consistently stored between 2 and 8 degrees Celsius. But the team members did not know how to reset the thermometer and a check of both the built-in thermometer and a stand-alone thermometer in the fridge showed that the temperature had reached 11.8 degrees Celsius at some point. Staff said they thought this was an isolated occurrence but as the thermometer was not being reset, it was difficult to confirm one way or the other. The team said that they would monitor this carefully and ensure the thermometer was reset regularly. The pharmacy stored its CDs securely. The pharmacy checked each CD prescription on collection to help ensure that medicines were not issued after the prescription was no longer valid.

The pharmacy team dispensed medication into multi-compartment compliance packs for some people who had difficulty managing their medicines. These were disposable, tamper-evident, and had descriptions of the medication included in the pack labelling. The descriptions helped the person or their carer to identify the medicines. The pharmacy routinely supplied patient information leaflets with packs to people. There were four packs of medication for a person which had been left open on the bench for 24 hours as there was a query about changes to their medication. This posed a risk of medicines jumping between compartments if the pack was knocked and the packs potentially becoming

contaminated. These were immediately sealed and the team members said that they would seal the packs in the future. Packs for another person had been assembled before the prescriptions had arrived. The pharmacy had record sheets to record any changes to medication in the packs and to help with effective team communication. The current team had redesigned the process for the packs as the team member previously responsible for this activity had left the pharmacy at short notice without briefing another team member. The person's GP requested when people should receive their medication in compliance packs. The pharmacy did not conduct a needs assessment before starting people on the packs and the benefits of this were discussed.

The driver had 'missed delivery' cards and coloured stickers for controlled drugs and refrigerated items to ensure appropriate storage. There was a record sheet with an audit trail to show the medicines had been safely delivered. The pharmacist had undertaken anaphylaxis training. Pharmacy staff described a safe procedure for handling needles in the pharmacy and had received training in needlestick injury avoidance. The adrenaline pens in the cupboard had expired but the pharmacist said that they would replace these before starting the new flu vaccination season.

Medicines which people had returned were clearly separated into designated bins and disposed of appropriately. Drug alerts were received electronically and recorded in the pharmacy. There was evidence that the pharmacy team members had appropriately actioned recent alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services and it largely maintains it appropriately. The pharmacy uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had up-to-date reference sources, and testing equipment from reputable suppliers. It used stamped glass measures (with designated labelled measures for liquid methadone), and labelled equipment for dispensing cytotoxic medication such as methotrexate. This helped to avoid any cross-contamination. There was a blood pressure monitor. It was not certain when this had last been replaced or calibrated. The pharmacist said that they would look into this.

Fire extinguishers were serviced under an annual contract. All electrical equipment appeared to be in good working order and had been safety tested. Sensitive records were kept in the dispensary or upstairs in the building and the patient medication record was password protected. Confidential waste was disposed of using a locked bin for secure disposal offsite.

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.