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: 07/06/2023

Pharmacy context

The pharmacy is in a busy town centre and it receives most of its prescriptions electronically. It provides NHS dispensing services, and its additional services include the New Medicine Service, flu vaccinations, health checks and blood pressure checks. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and who need this support. And it provides substance misuse medications to a small number of people.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 protects people's personal information well. People can provide feedback about the pharmacy and its services. And team members take appropriate action to ensure that vulnerable people are safeguarded. The pharmacy keeps records about its services. But some of these are not readily accessible so it may be harder for the pharmacy team to answer queries quickly.

Inspector's evidence

There were documented, up-to-date standard operating procedures (SOPs) at the pharmacy. And team members had signed to show that they had read, understood, and agreed to follow them. 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 openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. And the pharmacy's head office was informed. The pharmacy manager said that she was not aware of any recent dispensing errors.

Team members used baskets to help minimise the risk of medicines being transferred to a different prescription during the dispensing process. And they kept their work areas free from clutter. There was an organised workflow which helped team members manage the workload. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members said that the pharmacy would remain closed if the responsible pharmacist (RP) had not turned up in the morning. And they knew which tasks they could and couldn't do if there was no RP signed in. Team members' roles and responsibilities were specified in the SOPs.

The pharmacy had current professional indemnity and public liability insurance. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not routinely recorded. The CD running balances were checked at regular intervals and any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right RP notice was clearly displayed, and the RP record was largely completed correctly. But there were several occasions recently where the RP had not signed out when they had finished their shift and a different pharmacist was working the following day. The pharmacist said that if a prescription-only medicine was supplied in an emergency without a prescription the medicine was labelled, and a record made on the patient's medication record (PMR). He said that the nature of the emergency was recorded. The pharmacist was not able to access the private prescription register or emergency supply record on the computer during the inspection. He

said that he would contact the PMR provider and ask that these records be made available.

Computers were password protected and people using the pharmacy could not see information on the computer screens. The pharmacy's 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 pharmacist said that there had not been any recent complaints received. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy's leaflet. The pharmacy manager said that people would usually raise a complaint directly with the pharmacy's head office and the pharmacy would be informed and asked to address the concerns.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. And other team members had undertaken safeguarding training provided by the pharmacy's head office. The pharmacy manager described potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. Team members could give examples of action they had taken in response to safeguarding concerns. 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 do the right training for their roles. They are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. And they can raise any concerns or make suggestions. 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, three trained dispensers (one was the pharmacy manager) and one trained medicines counter assistant (MCA) working during the inspection. Team members had completed an accredited course for their role. And they wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The pharmacy was up to date with its dispensing. There was a constant queue at the medicines counter which meant that dispensary staff had to break from the task they were carrying out to help cover the counter. Team members said that this caused distractions and breaks in concentration and could potentially increase the risk of mistakes being made. They mentioned that they had to re-check their work when they returned to dispensing to help reduce the chance of an error.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of medicines containing pseudoephedrine. And she 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. She asked people questions to check that the medicine they had asked to buy was suitable for the person it was intended for.

The pharmacist was aware of the continuing professional development requirement for professional revalidation. He has recently completed basic life support training and some virtual training about opioid de-prescribing. And he had completed declarations of competence and consultation skills for the services offered, as well as associated training. The pharmacy manager said that team members were not provided with ongoing training on a regular basis, but they did receive some. Recent training included, safeguarding, weight management, hay fever, asthma, urinary tract infections and sepsis.

Targets were set for the New Medicine Service. The pharmacy manager said that the pharmacy usually met the targets. The pharmacist felt able to make professional decisions. And said that the services were provided for the benefit of the patients. He would not let targets affect his professional judgement.

Team members had an informal huddle each morning to discuss any issues and to allocate tasks. They said that information was usually passed on informally during the day. Team members said that the pharmacy's head office carried out appraisals and performance reviews yearly for them. And they felt comfortable about discussing any issues with the pharmacist or making any suggestions.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was secured from unauthorised access and pharmacy-only medicines were kept behind the counter. Air conditioning was available, and the room temperature was suitable for storing medicines. And the pharmacy was bright, clean, and tidy throughout which presented a professional image.

There were three chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened and a coded lock was used to keep it secure when needed. 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

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services. But the pharmacy could do more to ensure that people who get their medicines in multi-compartment compliance packs receive all the information they need to take their medicines safely.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. 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 people who needed them.

Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said team members checked CDs and fridge items with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. And any who needed to be on the Pregnancy Prevention Programme had it annotated on their medication record. The pharmacy had spare patient information leaflets or warning cards available. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not always kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The pharmacy manager said that she would speak with the pharmacy's head office to discuss how these might be highlighted in future.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacist explained the action the pharmacy took in response to any alerts or recalls received from the pharmacy's head office. Any action taken was recorded and kept for future reference which made it easier for the pharmacy to show what it had done in response. Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. Stock due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. 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.

Part-dispensed prescriptions were checked frequently. People were kept informed about any supply issues with their medication and were provided an 'owings' note when their prescription could not be dispensed in full. Prescriptions for alternate medicines were requested from prescribers where needed.

And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked monthly. A prescription tracker system was used to help team members identify the location of the prescriptions. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacy manager said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for some people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. A team member said that people usually requested prescriptions for their 'when required' medicines if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled but the backing sheets were not attached to the packs, and this could increase the chance of them being misplaced. The dispenser said that she would ensure that these were attached in future. Medication descriptions were put on some but not all packs to help people and their carers identify the medicines. The dispenser said that she would ensure that these were recorded on all packs in future. The dispenser said that patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. She said that she would ensure that these were routinely supplied in future.

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.

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

Suitable equipment for measuring liquids was available and separate liquid measures were used to measure marked for certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any 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 was replaced in line with the manufacturer’s guidance and the weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.