General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Borno Chemists Ltd., 15 Broadway Market, Fencepiece Road, Barkingside, ILFORD, Essex, IG6 2JW

Pharmacy reference: 1031259

Type of pharmacy: Community

Date of inspection: 02/05/2019

Pharmacy context

This is a branch of a small group of pharmacies. It is situated on a busy main road, next door to a surgery. As well as dispensing NHS prescriptions, the pharmacy offers blood pressure checks and supplies medicines in multi-compartment compliance packs.

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 met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy doesn’t record the medicines fridge temperatures regularly.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally provides its services safely. It mostly keeps all the records it needs to by law. The pharmacy's team members understand their role in protecting vulnerable people. They undertake regular training to keep people's information safe.

Inspector's evidence

Standard Operating Procedures (SOPs) were in place but had not been reviewed since 2013. This could mean they do not reflect current good practice. The Responsible Pharmacist (RP) said that some SOPs were available on the group's training portal, 'Train Tracks'. However, not all SOPs including those for changeover of RP and operating in the absence of the RP were available. The SOPs on Train Tracks had no indication of when they had been implemented. The RP said that he had spoken to the area manager who had informed him that the SOPs were in the process of being updated. Following the inspection, the superintendent pharmacist (SI) confirmed that SOPs were reviewed annually or following any major incident or change in legislation. Release dates and version history were managed through the system administrator functions.

When the RP identified a near miss he handed the dispensed prescription back to the dispenser who had dispensed the prescription. And asked them to double check and identify the error and make a record on the log. The RP said that near misses were reviewed monthly. And actions from the reviews were recorded on 'huddle sheets' which were sent to head office. There were no completed huddle sheets available for inspection. Team members said that huddles (staff meetings) did not regularly happen and they had not held a discussion or been made aware of incidents that had occurred. The RP said that he had identified that the team member who prepared the multi-compartment compliance packs tended to make mistakes. He had asked her to double check her own work before handing it in for a final check. The team had also been asked to give longer waiting times if there were a number of people waiting for prescriptions.

Dispensing incidents were recorded on a patient incident report and a completed record was sent to head office who then reported the incident to the National Reporting and Learning System. As a result of the words 'keep refrigerated,' being covered, the pharmacy had changed the way in which they attached multiple labels to medicines. The pharmacy had received prompts to stick on shelf edges near where medicines which sounded or looked alike were kept.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. Professional Indemnity insurance was in place.

The pharmacy had a complaints procedure in place with a notice displayed. The pharmacy also completed an annual patient satisfaction survey. The RP tried to resolve complaints in store where possible, but people were given the contact details for the head office team if they wanted to escalate the matter further. As a result of feedback, the team had reviewed stock availability and made changes to reduce the number of owings. The RP said that he now reviewed the percentage of owings and tried and keep this below one percent.

Records for private prescriptions, emergency supplies, unlicensed specials and controlled drug (CD) registers were well maintained. RP records were generally well maintained but the pharmacist was not

always signing out. CD balance checks were carried out monthly. A random check of a CD medicine complied with the balance recorded in the register. CD patient returns were recorded in a register when they were received.

Assembled prescriptions were stored in the dispensary. Team members had completed training modules on Train Tracks which covered confidentiality and the General Data Protection Regulation. Team members had their own smartcards and only the RP had access to Summary Care Records. Consent to access Summary Care Records was gained verbally. Most confidential information was stored securely, but some was potentially accessible. The RP said that he would take action to address this.

The team had completed some training on safeguarding and the RP had completed a level 2 course. The RP said that details of the safeguarding boards were kept in the consultation room. Team members would refer to the RP if they had any concerns. In the past the RP had spoken to the surgery when he felt that a patient was not managing their medicines. The surgery next door had a special 'Care of the Elderly' nurse who the team would liaise with.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy well. And team members use their professional judgement to make decisions in the best interest of people. But they are not always given updates or have time set aside for training. This could limit the opportunities they have to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy team usually comprised of three dispensers, the RP and a medicines counter assistant (MCA) in the morning. One of the dispensers worked part time and finished in the afternoon. The RP had started working at the branch in November 2018 and since starting had recruited a dispenser. He said that he was in the process of recruiting another dispenser.

Team members had two reviews each year. Once completed information was sent to head office. The RP said that depending on performance if the team member moved up a band, there was potential of having a pay increase. During the review the team member and RP discussed what they thought they were doing well, any areas for improvement, training requirements and where they saw themselves in the future.

The trainee MCA counselled patients on the use of over-the-counter medicines and asked appropriate questions before recommending treatment, but said that she always checked with the RP before selling any medicines. She was also aware of the legal limits and age restrictions on the sale of certain medicines like pseudoephedrine. She described the way in which she would hand out prescriptions and was aware that controlled drug prescriptions were only valid for 28 days.

Team members on formal training courses were supported by the RP and were given training time when it was quiet. Team members also completed training modules on Train Tracks. Modules completed included: safeguarding, confidentiality and fire safety. There was no other procedure in place for keeping up to date and team members said that they had not all been made aware of the change in schedule of pregabalin and gabapentin.

Team members said that meetings were not regularly held, and information was not always cascaded to everyone. Information was sent from head office via emails and in the past had included information on the changes to selling oral lidocaine-based products for children. Pharmacy managers from all branches including the superintendent pharmacist were part of an electronic messaging group. Each Monday the team also received a weekly focus document, this covered how all the branches were doing and what areas stores needed to focus on. The RP said that he felt able to give feedback and suggestions, and on starting at the branch he had suggested that travel vaccinations be offered which had been taken on board. The team were also considering offering offsite flu vaccinations.

Targets were set for services and the RP said that stores were required to complete eight MURs per week and ensure that the level of owings was under one percent. The area manager called if targets were not being met. The RP said that a representative from head office came in once a month to see how the team were doing in terms of number of items, MURs and training completed. The RP said that there was no pressure to meet the targets and the targets did not affect his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides healthcare in a suitable space. The premises generally help protect people’s personal information.

Inspector's evidence

The dispensary was spacious with plenty of work bench space. The floors were clutter-free and clean. There was a clean sink with hot and cold running water in the dispensary for the preparation of medicines. Medicines were arranged on shelves in an organised and tidy manner. Cleaning was done by the team. The consultation room was spacious and tidy. he ambient temperature and lighting were suitable for the provision of pharmacy services. Team members said in summer it could get warm and they opened the front and back doors.

The premises were kept secure from unauthorised access. Most confidential information was stored securely, but some was potentially accessible. The RP said that he would take action to address this.

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

Summary findings

The pharmacy generally provides its services safely. But team members sometimes leave medicines in unsealed multi-compartment compliance packs over an extended period of time. This could increase the chances of mistakes being made. And it could affect the quality of the medicines. The pharmacy obtains medicines from reputable sources and mostly manages them well. But it does not always record the fridge temperatures. This could increase the risk that people get medicines that are not safe to use.

Inspector's evidence

Access to the pharmacy was via a low step; the RP said that they were in the process of having a bell fitted on the door and were trying to arrange to have a ramp available. The pharmacy was able to produce large print labels and backing sheets for visually impaired people. Members of the team were multilingual and spoke languages spoken by some local residents. The RP would also use translation applications available online.

Pharmacy services were advertised in the window and there was a small selection of pharmacy leaflets in the pharmacy. Team members were aware of the need to signpost people to other services and would find details of other providers from the NHS website or refer to a list in the consultation room. The patient medication record system had links to external website which all team members were aware of how to use.

The RP said that Medicines Use Reviews had the most impact on people. He said that most people using the pharmacy were registered with the surgery next door and because of the number of patients that were registered, prescribers did not always get time to discuss medicines in detail. The RP said it some cases he could potentially be the first health care professional that some people discussed their medicines with. The RP gave an example of a referral he had made to the GP where a person with a history of falls had been prescribed amitriptyline and gabapentin; the person was also taking other medicines which interacted with these. As a result of the review the amitriptyline had been stopped.

The pharmacy had an established workflow in place. Due to the health centre the pharmacy received some walk-in prescriptions but most prescriptions were received as six-monthly batches. Prescriptions were automatically printed, and the pharmacy used an electronic system which showed progress of the prescription at various stages of the dispensing process and finally showed which shelf it had been stored on. There were usually two people involved in the dispensing and checking process. It was very rare that the RP had to self-check. When he occasionally self-checked he described taking a mental break between dispensing and checking.

Dispensed and checked by boxes were available on the labels; these were initialled by the team to help maintain an audit trail. The pharmacy team also used baskets for prescriptions to ensure that people's prescriptions were separated and to reduce the risk of errors.

Dispensers would pass any prescriptions for sodium valproate to the RP, who was aware of the change in guidance for dispensing this medicine. The RP said that anyone in the at-risk group would be referred back to their GP if they were not on effective contraception. The pharmacy did not have any regular patients in the at-risk group.. The RP tried to dispense sodium valproate and methotrexate in its original packaging. The patient medication record system automatically printed warning labels for sodium

valproate. The pharmacy did not dispense prescriptions for warfarin as the contract for monitoring INR and supplying warfarin was held by another local pharmacy. Before supplying methotrexate, the RP checked if the person had regular monitoring. Different strengths of methotrexate had also been separated to help reduce picking errors.

For people who had their medicines supplied in multi-compartment compliance packs the pharmacy ordered prescriptions six days in advance of them being due. Around 99% of patients on the service were registered with the surgery next door. Packs were labelled and prepared by the dispenser and then checked by the pharmacist. The RP used the repeat slips to check for any changes or omissions and the dispensers flagged any new medicines. Any changes were first checked with the person and then with the surgery if they were unsure. A record of the confirmation was made on the patient medication record. Multi-compartment compliance packs were prepared on the back bench to reduce the risk of distractions. The RP had set up a timetable to help get the multi-compartment compliance packs service on track since he had started.

Seven prepared unsealed trays were observed on the shelves used to store the multi-compartment compliance packs. The lids to these had been closed and the trays were stacked on top of each other. Team members said that they had been prepared in the days before the inspection. Assembled packs observed were labelled with product descriptions and mandatory warnings. Patient information leaflets were handed out monthly. There was an audit trail in place to show who had dispensed and checked the packs. However, backing sheets had been placed loosely within the trays. This means that if they were lost, people may not always have the information they need to take their medicines safely.

Deliveries were carried out by a designated driver who obtained signatures for CDs delivered but not for other medicines. This could make it harder for the pharmacy to show that people had received the medicines safely. In the event that the person was not available, medicines were returned to the pharmacy and delivery was reattempted the following day.

Medicines were obtained from licensed wholesalers and mostly stored appropriately. This included medicines requiring special consideration such as CDs, which were kept securely. But a small number of medicines were not stored securely. The RP said that fridge temperatures were monitored daily. However, the last time the temperature had been recorded was on 19 February 2019 and prior to that on 11 February 2019. The upper temperature reading was also not working on the probe.

Date checking was done every three months by team members who were allocated sections to check. They recorded this, but a date expired medicine was found on the shelves sampled. This increased the chance the medicine could be given out when it had passed its ‘use by’ date.

The pharmacy had all the equipment installed for the Falsified Medicines Directive (FMD). However, the RP said that at the request of the area manager they had not started using this.
Out-of-date and other waste medicines were segregated and then collected by licensed waste collectors.

Drug recalls were received via email from head office. The RP printed these and actioned them after which records were kept in the dispensary. The pharmacist signed when alerts had been actioned. The email was accessible to all team members. The last actioned recall was for prednisolone tablets.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it generally looks after them properly. But it does not always keep records of when equipment is replaced or recalibrated. So, it could be harder to show the equipment can give accurate readings.

Inspector's evidence

The pharmacy had glass calibrated measures, and tablet counting equipment. Equipment was clean and ready for use. The pharmacy had a fridge of adequate size for the storage of medicines. A blood pressure monitor was available. The RP was unsure of how old it was and there were no records available to show when it had last been calibrated.

Up-to date-reference sources were available including access to the internet.Computers were all password protected and could not be seen by members of the public. Confidential waste segregated and collected by a licensed company.

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.