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: 15/01/2020

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. It provides Medicines Use Reviews (MURs) and New Medicine Service (NMS) checks.

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

The pharmacy's working practices are generally safe and effective. The pharmacy protects people's personal information adequately. And it asks its customers for their views. It largely keeps the records it needs to so that medicines are supplied safely and legally. The team members generally respond appropriately when mistakes happen during the dispensing process. But they don't always review these mistakes. So, they might be missing opportunities to learn and make the services safer.

Inspector's evidence

Standard Operating Procedures (SOPs) were available electronically and accessed via the group's training portal, 'Train Tracks.' SOPs were assigned to team members profiles centrally by head office and were assigned depending on their job roles. An administrator at the company's head office also checked if team members had completed reading the SOPs. Team roles were defined within the SOPs. The store manager from a nearby store confirmed that the team were up-to-date with reading SOPs.

The Responsible Pharmacist (RP) handed back dispensed prescriptions to the dispenser when near misses were identified. Dispensers were asked to identify their mistake and rectify it. These were then recorded on a near miss record sheet. Some near misses from January 2020 were seen to be recorded. Team members could not locate the record sheet from December 2019 and there was no evidence of any reviews being carried out.

Dispensing incidents were recorded on a patient incident report and a completed record was sent to head office. At the end of each month details of learning from incidents was shared with all branches by head office. Previously the team had received prompts to stick on shelf edges near where 'look-alike, sound-alike' (LASA) medicines 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 layout of the retail area had been changed and the team had implemented a cleaning and date checking rota.

Records for 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. Private prescription records did not always have the date on the prescription recorded and the prescriber's details were also not always correct. This could make it harder for the pharmacy to find out this information if there was a future query. 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 supporting pharmacy manager 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. Details of the safeguarding boards were available. Team members would refer to the RP if they had any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for its services, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively. Team members get time set aside for ongoing structured training. This helps them keep their knowledge and skills up to date

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP (a locum pharmacist), two trained dispensers (one of who was in the process of registering to become a technician), a trainee dispenser and a pre-registration trainee (pre-reg) who was due to re-sit their exam. The pharmacy had not had a regular pharmacist since May 2019. A new pharmacist was due to start working at the pharmacy in February. The pharmacy manager from a nearby branch visited the pharmacy regularly to support the team.

The RP felt that the pharmacy did not have enough cover on the medicines counter, a full-time medicine counter assistant had left in December. To help the team the pharmacy team in the interim they had been given the pre-reg until June. Team members covered the counter when needed. Team members were observed to be able to manage with the workload during the course of the inspection and were up-to-date with the dispensing.

Team members had previously had two reviews each year. However, since the pharmacy did not have a regular pharmacy manager, they had not had their most recent reviews. The pharmacy manager from a nearby branch visited at least once or twice a week to check up with team members. Some of the locum pharmacists provided team members with feedback.

The dispenser counselled patients on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was also aware of the legal limits and age restrictions on the sale of certain medicines like pseudoephedrine and was aware on what medicines were contra-indicated for certain conditions.

The store manager from the nearby store ensured team members were up-to-date with their ongoing training. They were given time in store to complete this. The last training module had covered updated dispensing SOPs and CPCS.

Team members on formal training courses had their training put on hold whilst there was no regular pharmacist. Team members also completed training modules on Train Tracks. Modules completed included: safeguarding, confidentiality and fire safety.

The pharmacy manager from the nearby store briefed the team on any changes or any information that needed to be cascaded down. 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 store manager from the other store briefed the team on this when he visited.

Targets were set for services such as MUR and NMS for locum pharmacist. There was some pressure on

the pharmacist to meet these. The RP said the targets did not affect her 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 room 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 and had fans.

The premises were kept secure from unauthorised access. The pharmacy had a consultation room which was spacious and tidy, but not all items inside it were kept secure. The RP said that she would take action to address this, and the room was locked during the inspection. The room allowed for a conversation to take place inside which would not be overheard.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. It obtains its medicines from reputable sources. And it largely manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts to make sure that people get medicines and medical devices that are safe to use. 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.

Inspector's evidence

Access to the pharmacy was via a low step; the pharmacy was 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 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 she occasionally self-checked she 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 around pregnancy prevention when dispensing this medicine. The RP had carried out an audit on the use of sodium valproate and the pharmacy did not have any regular patients who fell in the at-risk group. The RP had not been aware of the need to use warning stickers if valproate was not dispensed in its original pack. The inspector reminded the RP of the requirements.

The pharmacy did not dispense prescriptions for warfarin as the contract for monitoring INR and supplying warfarin was held by another local pharmacy. The RP recalled one person presenting with a prescription for warfarin; details of monitoring had been checked but not recorded.

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 pharmacy had not carried out any reviews to check if the service was still suitable for people.

A number of prepared unsealed compliance packs for four to five people were observed on the shelves used to store the packs. The lids to these had been closed and the trays were stacked on top of each other. Some of these had been prepared on 7 January. The store manager from the nearby branch confirmed that he would review the SOP for the preparation of multi-compartment compliance packs with the team and he would work alongside the dispenser to coach her to ensure that the service was provided in line with the company policy. Assembled packs observed were labelled with mandatory warnings. Patient information leaflets were handed out monthly. There was an audit trail in place to show who had checked the packs but there was no record to show who had prepared these. Product descriptions were not included on the packs. Not having descriptions may make it difficult for patients and carers to identify which medicines are which.

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. Fridge temperatures were monitored daily and recorded; these were observed to be within the required range for the storage of medicines. CDs were held securely.

Date checking was done every three months by team members who were allocated sections to check. The date-checking matrix had not been updated since June 2019. Team members said that the dates had been checked in November 2019. A date-expired medicine was found on the shelves sampled. This could increase the chance that the medicine may be given out when it had passed its ‘use by’ date. Out-of-date and other waste medicines were segregated and then collected by licensed waste collectors.

The pharmacy had all the equipment installed for the Falsified Medicines Directive (FMD). The team was waiting to receive the ‘go-ahead’ from head office to start using the system.

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.

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 had calibrated glass 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 but thought it was new as it had not previously been there.

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.