General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Borno Chemists Ltd., 69 Perryman's Farm Road, Barkingside, ILFORD, Essex, IG2 7LT

Pharmacy reference: 1031289

Type of pharmacy: Community

Date of inspection: 29/08/2019

Pharmacy context

This pharmacy is located in close proximity to two GP surgeries in a largely residential area. People who use the pharmacy are mainly from the local area. The pharmacy supplies medications in multi-compartment compliance packs to people who need help managing their medicines. It provides Medicines Use Reviews and New Medicine Service checks to people.

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	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
2. Staff	Standards met	2.2	Good practice	Team members get time set aside for training. Training is monitored and reviewed, with team members provided with feedback.
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 asks its customers for their views. It keeps the records it needs to so that medicines are supplied safely and legally. Team members know how to safeguard vulnerable people. They are good at recording and learning from any mistakes. This helps them make the pharmacy’s services safer.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which were available electronically on the company’s training portal ‘Train Track’. 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. New team members read SOPs as part of their induction period. Team roles were defined within the SOPs. SOPs were also available on an electronic drive in the dispensary so that they could be read by locum pharmacists.

Near misses were brought to the attention of the person making the mistake and recorded. Near misses were analysed each month to identify any trends and patterns as well as identifying when most mistakes were happening. As a result of past reviews, the team had separated stock on the shelves. The store manager was a trained dispenser and had only started working at the pharmacy a short time before the inspection. He said that when he had first started, due to the way in which the stock was arranged, he had to take a step back and think about what he was picking. As a result of this he had noticed that he was making fewer mistakes than at his previous pharmacy. The completed patient safety report was sent to head office. The team held a meeting each Tuesday, to go over the previous week’s figures as well as discussing any serious near misses and dispensing incidents. The store manager was due to attend his first managers’ monthly meeting and said that he thought learning from incidents may be shared. The team had also attached stickers near where ‘look-alike sound-alike’ (LASA) medicines were stored on the shelves. Prompts were also attached in the dispensary to remind team members to check: the name of the medicine, the pack size, the strength and the expiry date when dispensing.

Dispensing incidents were recorded on the system which automatically submitted a copy to head office. As a result of an incident involving montelukast and mirtazapine, both items had been separated on the shelves. A warning label had also been attached to the shelf edge, prompting people to take care when selecting the item. In the event that the person had taken the incorrect medication the responsible pharmacist (RP) would contact the GP and the person would be referred to the hospital or their GP depending on the effects. The store manager would also speak to his line manager and discuss any dispensing errors and any proposed actions to be taken.

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.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and also completed an annual patient satisfaction survey. A notice was also displayed in the retail area to explain to people how they could provide feedback or make a complaint. People could call one of the two area managers or speak directly to the RP or store manager. After receiving feedback, the store manager had rearranged the shop floor to ensure medicines for certain conditions were

stored together. Since doing this he had received feedback from people to say that the medicines were easier to access.

Records for private prescriptions, emergency supplies, unlicensed medicines, RP records and controlled drug (CD) registers were well maintained. CD balance checks were usually carried out monthly. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received.

Assembled prescriptions were stored so that they were not visible to people using the pharmacy. Team members had individual smartcards to access NHS systems. The RP had access to Summary Care Records. Consent to access these was gained verbally and recorded on the patient medication record. An information governance policy was in place and team members had completed training on Train Track as well as signing a confidentiality agreement.

The RP had completed the level 2 safeguarding course and other team members had completed internal training on ‘Train Track’ and were able to describe the actions that they would take in the event that they had any concerns. Contact details for local safeguarding boards were available.

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 trained dispenser plus the store manager (also a trained dispenser) and two trained medicines counter assistants (MCA). The RP felt that there were an adequate number of team members for the services provided.

Team members' performance had been managed by one of the managers from head office who had come in monthly when there had not been a regular store manager. Team members had a formal annual review with three-monthly reviews in between. New starters had a six-month probation review. The store manager would carry out reviews and send information to head office. The RP also provided team members with feedback. As part of the review further training was also looked at. Following the last appraisal, the dispenser was told that she would be enrolled on NVQ 3 dispenser training programme.

The MCA 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. She described the way in which she would hand out prescriptions and was aware that controlled drug prescriptions were only valid for 28 days. She also described that when presented with a prescription for a controlled drug she would check the date the prescription had been issued and the way in which the dosage instructions were written before handing the prescription to be dispensed.

Team members also completed training modules on Train Tracks. Modules completed included: safeguarding, confidentiality and fire safety. Team members were given time to complete this training at work. The last training had covered hay fever products. The store manager said that he was notified with details of any new training or SOPs that were uploaded to Train Tracks. He was also given information in relation to dates of when training needed to be completed by.

The team had a huddle each Tuesday. If all team members were not present during the huddle the store manager would brief individuals when they started their shift. During the huddle team members were given the opportunity to share ideas. The team felt able to raise concerns, give suggestions or feedback ideas to the RP or store manager. They said that both were open and approachable and listened to what people had to say. Team members were also able to contact head office directly if they had any concerns.

Managers' meetings were held monthly at head office. The store manager was due to attend his first meeting since starting with the company. Each week the store manager also had a one-to-one conversation with his line manager to discuss what had happened in the previous week. The store manager felt that the team were receptive to ideas suggestions and feedback he had provided since starting.

There were no numerical targets in place and the team was encouraged to provide services. The RP said that this would not affect his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are mostly clean and tidy. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was tidy and clean; cleaning was carried out by team members daily with a rota in place. Work bench space was limited but this was roughly allocated for certain tasks and kept clear of clutter. Stock was held in an organised manner. A sink was available in the dispensary for the preparation of medicines.

The out-building (a converted garage) had benches which were clear of clutter. There were some cobwebs in the room. The retail area was clean, professional in appearance and had chairs for people waiting for a service.

The consultation room was clean and was accessed from behind the medicines counter. There were a number of folders in the room which the RP and store manager said would be moved elsewhere.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. Air conditioning was available to help regulate the temperature in the main dispensary. The store manager said that he was looking into getting an air conditioning unit for the out-building.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner. It obtains its medicines from reputable sources. And it generally manages them appropriately so that they are safe for people to use. People with a range of needs can access the pharmacy’s services.

Inspector's evidence

There was step-free access to the pharmacy via a ramp. There was easy access to the medicines counter with chairs available in the waiting area. The team had the ability to print large print labels and for some people had made a record on the electronic patient record to ensure the braille on medicine boxes was not covered. Team members would assist people who needed help and had completed training courses on topics such as dementia. The team was multilingual and the RP also used online translation applications. Some people preferred to call or come in with family members who spoke English.

There was a range of leaflets in the retail area and services were advertised in the window. Team members were aware of the need to signpost customers to other providers if a service was not available at the pharmacy, for example to other pharmacies, GP surgery or local diabetic clinic. A signposting folder was available in the consultation room and the team also used the internet to find services.

The RP felt that the Medicines Use Reviews (MURs) had the most impact on people. He said that it allowed him to pick up on interactions that may have been missed and to then make referrals. He gave an example of someone who was referred back to their GP as they were taking a high dose of simvastatin at the same time as taking amlodipine. The pharmacy had two surgeries nearby, one of which was across the road. The team had worked together with the surgery on a campaign to reduce medication wastage. As part of this at the point of handing the prescription out, team members asked people to check their medicines and see if there was anything they did not need. Due to the relationship between the surgery and the pharmacy the RP said that the surgery felt confident to refer people to the pharmacy and frequently referred people to have their inhaler technique checked and rectified.

The pharmacy had an established workflow in place. Most prescriptions were received electronically and a majority were repeat prescriptions. To manage the workflow and ensure prescriptions remained separate the team used colour coded baskets. Prescriptions were dispensed by one of the dispensers with the final check carried out by the RP. The RP said that it was very rare for him to self-check.

A dispensing audit trail was seen where the ‘dispensed’ and ‘checked’ boxes on the medication labels were initialled by team members. The RP also signed the prescription to show that he had clinically checked it.

The RP and dispenser were aware of the change in guidance around pregnancy prevention for dispensing sodium valproate. The team had displayed a poster in the dispensary to act as a prompt and the ‘Prevent’ pack containing leaflets and warning labels was also available. The RP had had a conversation with the people in the at-risk group and the team were aware of the need to use warning labels when sodium valproate was not dispensed in its original pack.The RP had ordered steroid cards

and blank yellow books when he had started working at the pharmacy.The RP said that he checked the INR for one person who collected warfarin, but this was not recorded.

A list of people who were supplied their medicines in multi-compartment compliance packs was split into four, to help manage the workload. Prescriptions were ordered by the pharmacy with records kept allowing team members to chase up any prescriptions they had not received. An individual basket was in place for each person on the service which had a record of all their medicines. Any changes to prescriptions were queried with the GP, and a record was made on the person's individual record. In the event that someone was admitted into hospital, the pharmacy did not prepare or supply any further packs until confirmation of discharge along with a discharge summary was received. Packs were prepared by an allocated dispenser; however other dispensers were also trained. Packs were checked by the RP and then sealed. Assembled packs observed were labelled with product descriptions and mandatory warnings. Patient information leaflets were handed out monthly and there was an audit trail in place to show who had prepared and checked the packs.

Deliveries were carried out by a designated driver. Prescriptions were taken by the driver to obtain signatures for controlled drugs delivered. This posed a risk in the event that the prescription form was lost or misplaced. Records were kept for the driver for deliveries carried out. In the event that someone was unavailable a note was left and the medicines were returned to the pharmacy.

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. Some medicines were found to be stored in amber medicine bottles with no indication of batch numbers. This could hamper any action which would need to be taken in the event that there was a drug recall.

Expiry date checks were generally carried out routinely. When the store manager had started he initiated a new cycle and planned to complete a check every six weeks. There were no date-expired medicines found on the shelves checked. The team were unable to locate a recent date-checking matrix. The store manager said that he was in the process of introducing a new date-checking matrix. Out-of-date and other waste medicines were segregated from stock and then collected by licensed waste collectors.

The pharmacy had the equipment that it needed to comply with the Falsified Medicines Directive (FMD). Team members said that the FMD system was being trialled in one of the company's other branches. And that the team members were due to receive training. The team was unsure of when the FMD system was due to be launched.

Drug recalls were received via email and were printed and attached to the patient safety review. The team members said that they last alert that they had acted for was an inhaler for which people had to be contacted. The pharmacy had also received the more recent recall for Aripiprazole which they did not have in stock.

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. A separate tablet counting triangle was used for cytotoxic medicines to avoid contamination. A medical fridge of adequate size was also available.

Up-to-date reference sources were available including access to the internet. The computer in the dispensary was password protected and out of view of people using the pharmacy. Confidential waste was segregated and collected in a locked bin and sent for destruction.

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.