General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Minal Pharmacy, 9-11 High Street, Whitton, TWICKENHAM, Middlesex, TW2 7LA

Pharmacy reference: 1035156

Type of pharmacy: Community

Date of inspection: 08/11/2022

Pharmacy context

This is an independent community pharmacy. It is on a busy high street in the centre of Whitton. The pharmacy provides a range of services including dispensing prescriptions. And it supplies medicines in multi-compartment compliance packs for people living at home who have difficulty taking their medicines. It has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a core range of other services including a flu vaccination service, a free emergency hormonal contraception service and health checks.

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 not all met	2.2	Standard not met	The pharmacy does not train all of its staff properly for the tasks they carry out.
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 does not do enough to ensure that it stores all of its medicines tidily. And in the appropriate packaging.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

In general, the pharmacy has adequate procedures to identify risk. It has written procedures in place to help ensure that its team members work safely. The pharmacy has insurance to cover its services. And it satisfactorily manages any concerns that people have. The pharmacy knows how to protect the safety of vulnerable people. And, in general it ensures that it keeps all of its records in the way it should.

Inspector's evidence

The pharmacy had a system for recording its mistakes. The responsible pharmacist (RP) who was also the superintendent pharmacist (SP) described how he and his pharmacist colleagues highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistake from happening again. In response to several near miss mistakes, team members had separated look-alike sound-alike medicines (LASAs), such as amlodipine and amitriptyline. But while the team recorded its mistakes, it did not record much detail. And it did not record what it had learned or what it would do differently next time. The SP and other team members understood that if they had more details of what they had learned from their mistakes it would help reduce the risk of similar mistakes in future. The pharmacy did not review its near misses regularly. But the team agreed that it was important to do so. So that it could identify any underlying trends and improve further. And that this was especially important for team members in training. The pharmacy had put measures in place to keep people safe from the transfer of viral infections. It had put screens up at its medicines counter. And it had hand sanitiser for people and the team to use.

The pharmacy had a set of standard operating procedures (SOPs) to follow. The SP had recently introduced a new updated set of SOPs. One of the trainee dispensing assistants (DA)s described how she would read one of the new SOPs when an activity relevant to it came up in her training. And while team members had not yet read all the new SOPs they had all read the previous ones. The second trainee DA understood her role and responsibilities. She described how she manged people coming into the pharmacy for a flu vaccination. She described how she would give each person a questionnaire which they had to complete. The questionnaire was to establish whether they were entitled to have a vaccination. She would then book an appointment for them or refer them to the pharmacist for a vaccination at the time. And she consulted the SP when she needed his advice and expertise. The SP had placed his RP notice on display showing his name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services. And the team sought feedback day to day by talking to people about the pharmacy's services. Team members described having had a few complaints. Complaints had been related to people's expectations involving the time taken to get their medicines ready when the pharmacist was busy with flu vaccinations. But the team resolved this by explaining to people that the pharmacist was engaged in providing another service. The pharmacy had also received concerns from people when their medicines weren't ready when they expected them to be. And so, staff regularly advised people to allow more time between ordering their prescriptions and collecting them. The team did this so that it had enough time to order people's medicines, deal with any problems and dispense them. The pharmacy had a complaints procedure in place. It could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure online. But customer concerns were generally dealt with at the time by the regular pharmacists or by the superintendent (SP)

if necessary. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers. It had professional indemnity and public liability insurance in place until 31 August 2023. It is understood that when this date is reached the pharmacy will renew its insurance arrangements for the following year.

The pharmacy generally kept its records in the way it was meant to, including its controlled drug (CD) registers, its private prescription records and its records of CDs which had been returned by people for safe destruction. The pharmacy kept records of emergency supplies. But it did not always record the reason for making the supply as required by law. The pharmacy's RP record was generally in order, but it had some omissions where RPs had forgotten to log out at the end of their shift. The team recognised that the pharmacy should ensure that all of its essential records are kept the way they should be. And that its records are accurate and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And had completed general training on confidentiality. Confidential paper waste was discarded into separate waste containers. And it was shredded regularly. People's personal information, including their prescription details, were generally kept out of public view. But the pharmacy placed its dispensed prescription tokens in a basket on top of the surface in front of the main dispensary computer. And while people would not usually interfere with these, there was a risk that they could view them unintentionally. The RP had completed appropriate safeguarding training. Other team members had been briefed although had not yet had any formal training. but they knew to report any concerns to the RP. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not adequately train all its team members for the tasks they carry out. And it does not train all of its team members according to General Pharmaceutical Council guidance. But team members support one another. And they are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services. In general, the pharmacy team satisfactorily manages its workload.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. The team consisted of the SP RP, an accredited checking technician (ACT), two trainee pharmacy assistants (PA)s and a trainee PA who had not yet been registered on a recognised training course. The role of a PA was to combine NVQ2 dispensing assistant training with medicines counter assistant (MCA) training. The trainee PA who not yet started any formal training, had worked at the pharmacy for almost a year. And he was observed dispensing medicines into multi-compartment compliance packs. This is an activity which needs NVQ2 training. The SP agreed that if the trainee was to continue with dispensing activity, he should be registered on a recognised training course as soon as possible. The SP was supported on several days a week by a regular part-time locum who was not present at the time of the inspection. Overall, team members were seen to support one another with their tasks. They attended to the pharmacy's customers promptly. And they were up to date with the daily workload of prescriptions. RPs could make day-to-day professional decisions in the interest of patients. And in general team members could discuss their concerns with the SP. But the pharmacy did not have a process for providing all of its trainees with feedback which would help them improve. And it did not provide formal appraisals or reviews about each team member's work performance. In general staff were kept up to date and supported in their work by the RPs and the SP. Pharmacists could make their own professional decisions in the interest of people and were not under pressure to meet additional business or professional targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an adequate environment for people to receive its services. And they are generally clean and secure. The pharmacy has made some sensible adjustments to help keep people safe from the transfer of infections. But the pharmacy's decor is not sufficiently up to date. And it needs to be refreshed. Several areas are cluttered and untidy. And its workspace and its customer areas do not fully benefit from the total space available.

Inspector's evidence

The pharmacy was on a busy local high street. And it had a traditional appearance. The customer area had seating for waiting customers. And it had a gondola which it used to display healthcare related items. It also stored nutritional supplement drinks for prescription orders here and on the floor beside it. The medicines counter supported a transparent plastic screen on both sides to help reduce the spread of viral infections. And the pharmacy kept its pharmacy medicines behind the counter. The pharmacy's dispensary had an 'L' shaped dispensing surface which it used for most of its dispensing activities. And it had storage facilities above and below this. The pharmacists' accuracy checking bench faced the customer area so that team members could see people waiting. And it had a separate, more discreet area for handing out some prescriptions, including methadone prescriptions. The ACT generally dispensed and accuracy checked prescriptions here too. The team had a cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. But the pharmacy's worksurfaces and floors were generally cluttered with stock and prescription baskets with incomplete prescriptions and paperwork. The pharmacy's décor had not been updated for several years and walls and floors looked scuffed and marked.

The pharmacy had two consultation rooms. The pharmacy used one of the rooms for chiropody services. And it used the same room for private pharmacy consultations. This room was clean, tidy and professional looking. The pharmacy's other consultation room was used less often for consultations. It had trays of medicines on the floor alongside staff bags and trays of medicines. Staff coats were also stored here. It had two small desk areas. One desk area was used for training and administrative work and the other was used for making up multi-compartment compliance packs. Overall it was cluttered and untidy. And as it had a glass door, the clutter could be seen by people looking in. The back-shop area also contained staff facilities. The pharmacy had a stock room. The stock room had stock on shelves. But it also had a significant amount of rubbish on the floor and bags of piled up confidential waste and boxes of sundries. It would be difficult to access all areas of the stock room because of the clutter. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

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

Summary findings

The pharmacy is not thorough enough in ensuring that it keeps all its medicines for dispensing in the appropriate packaging. And it does not do enough to ensure that all the medicines it supplies have the information that people need so they can take their medicines properly. In general, the pharmacy makes its services accessible for people. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbein

Inspector's evidence

The pharmacy had step-free access. And while most of its customer area was free of unnecessary obstacles, the area around the gondola had tote boxes and stock on the floor. This would make access to these areas difficult for people, especially those with mobility issues or anyone using a wheelchair. The pharmacy had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions for them if necessary. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. It provided medicines in multi-compartment compliance packs for people living at home who needed them. And for people living in care home and nursing home environments. The pharmacy labelled its compliance packs with directions which gave the required advisory information to help people take their medicines properly. And a description of each medicine, including colour and shape, to help people to identify them. But while the pharmacy supplied patient information leaflets (PILs) with new medicines it did not give them with regular repeat medicines. This meant that it did not regularly give people all the information it should about their medicines. The RP gave people advice on a range of matters. And he would give appropriate advice to anyone taking high-risk medicines. The RP had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The inspector and RP discussed the precautions the RP should take, and counselling he should give, if it were to be prescribed for someone new.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines appropriately and in their original containers. But the inspector found a box of tablets which contained mixed batches of different brands. This meant that the information on the outside of the packs did not accurately describe what they contained. And it increased the risk of mistakes. This could happen if some of the contents had been recalled. And expiry dates on individual strips could be missed during the usual checks. Some of the strips of tablets had also been part-dispensed with their expiry dates removed. The inspector discussed this with the team. It was agreed that team members should review their understanding of the correct procedures to follow when dispensing a split-pack of medicines. And when putting medicines back into stock after dispensing.

Stock on the shelves was untidy and disorganised in several places. And while the team had previously carried out regular date checks they had not had the resources to do this in recent months. But the RP and MCA DA described how they usually checked expiry dates when they dispensed and accuracy checked every medicine. And a random sample of stock checked by the inspector was in date. In general, short-dated stock was identified and highlighted. And the team put its out-of-date and patient-returned medicines into dedicated waste containers. The team stored its CD and fridge items

appropriately. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. It had two computer terminals in its dispensary. And it had a computer in the main consultation room. Computers were password protected. And were not in people’s view. Team members had access to personal protective equipment in the form of gloves and masks. And they had access to a range of up-to-date reference sources.

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.