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: 28/09/2023

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.

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 not all met	1.1	Standard not met	The pharmacy does not identify and manage the risks associated with all its services adequately.
		1.6	Standard not met	The pharmacy does not ensure that it keeps its records in the way the law requires.
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 does not store all its medicines in appropriate packaging which is properly labelled. And it does not make all the checks it should to ensure that its medicines are safe to use to protect people's health and wellbeing.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not do enough to identify and manage the risks associated with all its services. It has written procedures in place to help ensure that its team members work safely. But it does not ensure that its team members understand and follow them properly. And it does not ensure that it keeps its records in the way the law requires. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information suitably.

Inspector's evidence

The pharmacy had a system for recording its mistakes. The responsible pharmacist (RP) who was a regular locum 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. And she reviewed them with the team every month. But the pharmacy did not record what it had learned or what steps team members could add to their own procedures to prevent future mistakes. This was identified at the last inspection. The RP and inspector agreed that it was important to ensure that all near miss mistakes should lead staff to reflect on their own dispensing procedures. And improve them. In response to several near miss mistakes in the past, team members had separated look-alike sound-alike medicines (LASAs), such as amlodipine and amitriptyline. It had done this to reduce the risk of selecting the wrong one. But the team had recorded only one near miss in the last four months. Records prior to that were sporadic. And those which had been recorded did not give much detail. This meant that there was not as much information as there could be for monthly reviews. So, while it was clear that the team acted in response to its mistakes, the RP recognised that preventing mistakes also required on going monitoring and intervention. This would help staff to achieve on going learning. And improve their day-to-day practice.

The pharmacy had a set of standard operating procedures (SOPs) to follow. The superintendent pharmacist (SP) had introduced a new updated set of SOPs approximately one year ago. Staff said that they had all read them but only one member of the team had signed them to say that she had both read and understood them. Team members agreed that signing printed SOPs would provide a record of when they had last read them. And this would help to show when they should review their practice and read them again. The dispensing assistant (DA) understood her role and responsibilities. She was observed asking people the appropriate questions when they wanted to buy a pharmacy medicine. She did this so that she could ensure that the medicine was safe for them. And if she needed to, she could refer to the pharmacist and provide her with enough information to help her decision to intervene further or make a recommendation. The RP had placed her RP notice on display showing her 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. The team members had received a few complaints in the past. One complaint had been about the team handing out a person's blister pack without putting it in a bag. The person complaining was concerned about confidentiality. And so, the pharmacy now always put people's dispensed medicines in a pharmacy bag when handing them out. The pharmacy had also received concerns from people when their medicines were not 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.

The pharmacy did not keep all its records in the way it was meant to. Its private prescription records were complete and in order. But its RP record continued to have some omissions where RPs had forgotten to log out at the end of their shift. This had been highlighted at the previous inspection. The pharmacy kept records of emergency supplies. But it did not always record the reason for making the supply as required by law. This too had been highlighted at the previous inspection. The pharmacy's controlled drug (CD) registers, required a review. And its records of CDs which had been returned by people for safe destruction were not up to date. While the team recognised that the pharmacy should ensure that all its essential records are kept the way they should be. It had not yet taken the appropriate action to ensure this.

The pharmacy's team members understood the need to protect people's confidentiality. And they 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. The RP and Accredited checking technician (ACT) 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 met

Summary findings

In general, the pharmacy adequately trains its team members for the tasks they carry out. The pharmacy team generally manages its workload safely and effectively. And team members adequately support one another. In general, they are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

The responsible pharmacist (RP) was a regular locum. And had worked at the pharmacy on a regular part-time basis for several months. Pharmacist cover on remaining days was provided by the superintendent pharmacist (SP). On the day of the inspection the rest of the team consisted of the ACT, a pharmacy assistant (PA) who was trained as a dispensary asssistant (DA) and a medicines counter assistant, and a trainee DA. Overall, team members, attended to their allocated tasks. And the team attended to the pharmacy’s customers promptly. And it was up to date with the daily workload of prescriptions. Team members felt that they could discuss their concerns with the RP and the SP. They had team meetings every week. And they could request a one-to-one with the SP where they could discuss their concerns and their work performance. Team members felt that they could raise concerns and discuss issues with the SP. In general, 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. But the pharmacy's decor is not sufficiently up to date. And it needs to be refreshed. It is not sufficiently tidy and organised in some areas.

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 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 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. So, it was used less often for consultations. The room was generally tidy. The pharmacy had a back-shop area with staff facilities. And it had a stock room. The stock room had stock on shelves. But the room was cluttered and untidy. And it would be difficult to access all areas of the stock room because of the clutter. This was highlighted at the last inspection. 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 does not ensure that it keeps all its medicines for dispensing in appropriately labelled packaging. It also does not ensure that it stores them properly. And it does not make all the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy makes its services accessible for people. And it gets its medicines and medical devices from appropriate sources.

Inspector's evidence

The pharmacy had step-free access. And its customer area was generally free of clutter and unnecessary obstacles. It 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. And to prevent errors. 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. Compliance packs were usually assembled by the trainee DA and then checked by the ACT. Both the ACT and DA added their signatures to the packs to identify who had dispensed and checked them. But, in general, the process for including a pharmacist's clinical check of repeat prescription dispensing was unclear. It appeared that clinical checks took the form of a review by the trainee DA and or ACT who would alert the RP to any changes or problems. But the RP did not routinely assess people's repeat prescriptions for any clinical interventions which may arise from people being on the same medicines for some time. The inspector discussed this with the team who accepted that the process required a review. The pharmacy labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And it supplied patient information leaflets (PILs) with new medicines and at the beginning of the cycle for people that may require additional information about their medicine. And to help them to take their medicines properly. The pharmacy supplied methadone to people through its participation in local substance misuse services. After supplying daily methadone for supervised consumption, the pharmacy retained the bottles for reuse by the same person the following day. And so, the pharmacy did not supply their methadone in a new, clean dry container as every day.

The RP gave people advice on a range of matters. And she would give appropriate advice to anyone taking high-risk medicines. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP was aware of the precautions she would need to take, and counselling she should give, if it were to be prescribed for someone new. And she described how she would supply valproate medicines in the manufacturer's original packs in line with up-to-date guidance. Team members were aware of the need to supply the appropriate warning leaflets and cards each time. The pharmacy offered a microsuction ear wax removal service. And it had a fully trained member of the team who provided the service. She provided the service with the oversight of the RP. She had attended an intensive face-to-face training session, provided by an established training provider. And she kept records of each consultation. People identified as not suitable for the process had been referred to another healthcare professional where appropriate.

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 pharmacy's shelves were untidy in places. And the inspector found a pack of tablets which had fallen from the shelf above onto a bag of dispensed medicines below. The inspector and team members agreed that stock should be stored tidily. And they agreed that there was a risk of error if bags of dispensed medicines are stored on the floor directly below stock. The inspector also found packs of medicines which contained mixed batches and brands of the same medicine. This meant that the information on the outside of the packs did not accurately describe what was inside them. This could lead to errors if some of the contents had been recalled. And expiry dates on individual strips could be missed during the usual checks. The inspector also found several containers of tablets which were inadequately labelled. And one bottle had not been labelled at all. And so, there was an increased risk that the contents could be identified wrongly. The inspector discussed this with the RP. 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. This had been highlighted at the previous inspection.

The pharmacy checked the expiry dates of its medicines and devices every three months. But its records were not robust enough to identify which medicines were short dated. This posed a risk that medicines due to expire soon were not taken off the shelf. The pharmacy team members explained that they highlighted any short-dated stock so that it could be easily identified during the dispensing process. During the inspection, a random stock check found medicines which had expired. This was discussed with the team. And team members agreed that they should conduct a full date check of all stocks as soon as possible. And keep a full audit trail. Where appropriate, the team recorded the date of opening on liquid medicines. But it did not always discard them within an appropriate time once opened. But team members described how they checked expiry dates when they dispensed, and accuracy checked every medicine to ensure that the medicines they supplied were in date. The team put its out-of-date and patient-returned medicines into dedicated waste containers.

The team generally stored its CD items appropriately. And it had a fridge for storing its fridge items. But when asked, team members were not able to read fridge temperatures properly. And so, the records it kept were not accurate. The inspector discussed this with the team who agreed that all dispensing team members should be re-trained on how to read the maximum and minimum temperatures on the fridge thermometer. And on how to reset it every time a reading is taken. The team understood that keeping accurate records of fridge temperatures would ensure that they could monitor fridge temperatures properly and provide assurance that the medicines within it were being stored appropriately. The pharmacy responded promptly to drug recalls and safety alerts. And it kept records of these. 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. And team members had access to a range of up-to-date reputable reference sources. 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 their own smart cards. But occasionally they shared each other’s although they understood the importance of using their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in shelves which were out of people’s view.

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.