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: 06/06/2024

Pharmacy context

This is an independent community pharmacy 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 the NHS Pharmacy First service. And 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 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 does not do enough to ensure that it manages all the medicines it receives properly.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future. The pharmacy has insurance to cover its services. And its team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy has written procedures in place to help ensure that its team members work safely. The pharmacy adequately completes all the records it needs to by law.

Inspector's evidence

The responsible pharmacist (RP) worked one day per week at the pharmacy. She described how she highlighted and discussed dispensing 'near misses' and errors at the time with the team member involved. This helped them to learn from their mistakes and prevent them from happening again. The pharmacy had recently introduced a new electronic system for recording its mistakes. It had a scannable QR code fixed on the wall close to its workspace. And when the RP identified a mistake, the team member scanned the QR code on their phone. This took them to the near miss reporting system so that they could record what had happened. The system required team members to identify the type of mistake from a list. And the reasons for it. And it required them to reflect on what action they would take to prevent a re-occurrence. The superintendent (SI) then reviewed the records regularly. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). And in response to several near miss mistakes with LASAs, it had separated similar items such as metformin and metformin SR, by placing other items between them. It had done this to reduce the risk of selecting the wrong medicine. The team recognised that preventing such mistakes required on going monitoring and intervention. And it was clear that the team discussed what had gone wrong. And it acted in response to its mistakes. Team members agreed that near misses should lead them to identify the steps they could introduce to their own procedures to help them learn and improve.

The pharmacy had a set of standard operating procedures (SOPs) to follow. Team members had read the SOPs relevant to their roles. But several team members had yet to sign them. The accredited checking technician (ACT) had worked at the pharmacy for several years. She was an established member of the team. And she consulted the RP or superintendent pharmacist (SI) when she needed their advice and expertise. Team members asked appropriate questions before handing peoples prescription medicines to them. Or selling a pharmacy medicine. They did this to ensure that people got the right advice about their medicines. They were observed to attend to their allocated tasks, prioritising the most urgent prescriptions and using the pharmacy's patient medication record system (PMR) competently. The RP had placed her RP notice on display. The notice showed her name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy also had a complaints procedure to follow. And the team could provide people with details of where they should register a complaint if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. Team members commented that, at times, people were concerned when their prescription had not arrived or that their medicines were not ready or available. These issues were often out of the pharmacy's control, as the problem often arose with medicines which were unavailable

from the manufacturer. Or when the pharmacy had not yet received the prescription from the surgery. But, to help the situation, the team chased prescriptions up when they could. And they also worked closely with local surgeries to arrange for alternatives when they received a prescription for an item that they could not get. The pharmacy also tried to keep people's preferred brands of medicines in stock so that their medicines were available for them when they needed them. The small team was observed handling people's queries well. 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's private prescription records were complete and up to date. And in general, its controlled drug (CD) registers were in order. The pharmacy had a record book for recording CDs which had been returned for destruction. The pharmacy maintained running balances of its CDs. And the quantity of a random sample of stock checked by the inspector corresponded to the running balance in the register. The pharmacy's emergency supply records were in order. And the team recognised that records needed a clear reason for supply. The pharmacy's RP records were also generally in order, but it had some omissions where RPs had forgotten to record the time at which their responsibilities ended for the day. This had been highlighted at the previous two inspections. The RP and SI understood that the pharmacy should ensure that all its essential records are accurate and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed general training on confidentiality. The pharmacy discarded its confidential paper waste into separate waste containers. This was collected regularly for secure disposal by an appropriate licensed waste contractor. Team members kept people's personal information, including their prescription details, out of public view. The RP and SI had completed appropriate safeguarding training. Other team members had been briefed. And they knew to report any concerns to the RP. The team could access details for the relevant safeguarding authorities online. But they had not had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained and skilled team members for the tasks it carries out. The pharmacy team manages its workload safely and effectively. And team members support one another well. 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 RP was a locum. She generally worked at the pharmacy one day each week. Remaining days were covered by the SI. The SI arrived part-way through the inspection. He often attended the pharmacy when the RP was working, to assist. And to provide additional services or attend to his other tasks. On the day of the inspection the RP worked with the ACT, a trainee technician and two dispensing assistants (DAs). The trainee technician had recently begun his training through a local college apprenticeship scheme. At the pharmacy, he generally worked quietly on dispensing multi-compartment compliance packs in a separate room which was mainly used for this purpose. He did not usually work in the main dispensary or on the counter day-to-day. Team members were generally efficient and calm. And they supported one another, assisting each other when required. They attended promptly to people at the counter. And together they dealt with queries promptly. The pharmacy was up to date with the prescription workload. And most of its other tasks.

Team members did not have formal meetings or appraisals about their work performance. But they discussed issues as they worked. And they had occasional one-to-one meetings with the SI when required. They described feeling supported in their work. And they could make suggestions about how to improve the general workflow. They could also raise concerns with the RP if they needed to. The SI described how, with the support of the team he had introduced a new electronic system which the team now used to capture near misses and other mistakes. The team had also worked together to make better use of the pharmoutcomes electronic system. This had helped the team to see and act on any drug recalls from the MHRA more easily as well as improve record keeping for NHS services. This was an independently run pharmacy. And the RP felt she could make day-to-day professional decisions in the interest of patients.

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. It had a traditional appearance. And its customer area had seating for waiting customers. The pharmacy's medicines counter was at right angles to the dispensary which sat on a raised plinth alongside it. 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 looked over the customer area so that team members could see people waiting. And it had a separate, more discreet area around a short corner at the other end, away from the counter. It used this area for handing out some prescriptions for sensitive items or when discreet counselling was required. 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. Since the previous inspection the pharmacy team had worked hard to remove clutter and reorganise and improve its prescription storage system. But the pharmacy's décor had not been updated for several years and walls and floors remained 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. The room was also used for storing staff coats and bags. 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 remained 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 two inspections. 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 store all its medicines properly. But it gets its medicines and medical devices from appropriate sources. And it makes all the necessary checks to ensure that its medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy makes its services accessible for people. And it delivers them safely and effectively.

Inspector's evidence

The pharmacy had a small ramp providing step free access. But it used some areas of its retail space to store boxes of bulky stock and stacks of empty tote boxes. This meant that these areas were inaccessible for people using wheelchairs or with mobility issues. But the SI gave assurances that team members always assisted people who needed anything from this area. The pharmacy had a prescription 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 prevent error. 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 technician 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. And they referred to the RP when they required her clinical expertise and intervention. 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 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 the team were aware of the need to supply valproate medicines in the manufacturer's original packs in line with up-to-date guidance. The pharmacy team described how they asked people about any allergies when supplying their medicines. And recently had successfully intervened when a prescription for an antibiotic related to penicillin had been prescribed for someone who was sensitive to it. The SI provided the NHS Pharmacy First service. This allowed people to access medicines for seven common conditions after an appropriate consultation with him. And without having to see a prescriber. The pharmacy had received informal referrals from its local GP surgeries for the service. But most of its requests came directly from people. The pharmacist had the appropriate protocols to follow. And he kept the necessary records for each supply. It was clear that the SI understood the limitations of the service and when to refer people to an alternative health professional.

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 pack of medicines which contained mixed batches of two different brands of the same medicine. And they had different expiry dates. This meant that the information on the outside of the pack did not accurately describe what was inside it. And this 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. The inspector discussed this with the team. It was evident that from the last inspection the team had worked hard to ensure that its medicines were stored properly. But it recognised the need for further training to ensure that all team members, including trainees, understood that medicines should be store in their original packs where possible.

The pharmacy checked the expiry dates of its stocks, regularly. And it kept records so that team members knew what had been checked. And when. This meant that the team could monitor the pharmacy's entire stock for expiry dates effectively. When the team identified any short-dated items it highlighted them. And it only dispensed them with the patient's agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. The pharmacy responded appropriately 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. 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 its equipment was clean. Team members had access to a range of up-to-date reference sources. The pharmacy had several computer terminals which had been placed in the consultation room and in the dispensary. Computers had password protection. Team members generally used their own smart cards. And 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 the dispensary 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.