General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Whitton Corner Pharmacy, Whitton Community Centre, Percy Road, TWICKENHAM, TW2 6JL

Pharmacy reference: 1119746

Type of pharmacy: Community

Date of inspection: 08/02/2024

Pharmacy context

This is an independently owned local community pharmacy. The pharmacy is next to a purpose-built health centre on a busy intersection. It is in a residential area of Twickenham. And it provides a range of services including dispensing prescriptions. It has a small selection of over-the-counter medicines and other pharmacy related products for sale. It provides a selection of other services, including a winter flu vaccination service. And it provides the new NHS Pharmacy First Service.

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 has suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. 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 properly. The pharmacy 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.

Inspector's evidence

The pharmacy risk assessed its services. And it provided non-essential services when the workload allowed. The responsible pharmacist (RP) was the regular RP. And was also the manager. The pharmacy's main activity was its prescription dispensing service. The RP described how he generally highlighted and discussed prescription 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistakes from happening again. The team recorded its mistakes electronically. It had a scannable QR code fixed to its notice board. 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 RP then reviewed the records monthly. But the team did not appear to make many mistakes. And the RP reported that the number of near misses had reduced over the last six months. 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 placed warning stickers on the shelf edges in front of them. This included amitriptyline and amlodipine, rivaroxaban and rabeprazole. 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. 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 registered for the new NHS England Pharmacy First service. And it had introduced the service slowly while the RP became familiar with the protocols for treating each of the seven common conditions included. The RP described how a small number of people had requested the service for uncomplicated urinary tract infections (UTIs) in women. He had allowed an appropriate amount of time for each consultation to ensure that treatment under the service was appropriate and safe. He explained that he had taken extra time to do this as a precaution, while he became familiar with the service and became confident in delivering it.

The pharmacy had a set of standard operating procedures (SOPs) for its team members to follow. The SOPs were due to be reviewed by the superintendent (SI). But team members understood their roles and responsibilities. And they had all read and signed the existing SOPs. Including SOPs for selling pharmacy medicines and general items. And when handing out people's prescriptions. The technician and dispensing assistants (DAs) worked with the RP to get prescriptions ready for people. And they consulted the pharmacist when they needed his advice and expertise. They asked people appropriate questions about their prescriptions, to ensure they got what they needed. And they accessed, used and

updated the pharmacy's electronic records competently. The RP placed his RP notice on display showing his 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 had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint if they needed to. This included details for the superintendent pharmacist. 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. The RP 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. 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. And the technicians and DAs stepped in, unprompted, to support each other when needed. 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 kept its records in the way it was meant to, including its private prescription records, records for emergency supplies. And its controlled drug (CD) register. The pharmacy kept a record of its CD running balances. And a random sample of CD stock checked by the inspector matched the running balance total in the CD register. It had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. This was complete and up to date. The pharmacy's RP records were generally in order. But they had some omissions where the RP should have signed out at the end of their RP shift. The team agreed that it must ensure that all the pharmacy's essential records were up to date and complete.

The pharmacy's team members could explain the need to protect people's confidentiality. And they had completed appropriate training. They shredded confidential paper waste throughout the day, as they worked. And they kept people's personal information, including their prescription details, out of public view. The pharmacy had a policy on safeguarding vulnerable adults and children. And the RP had completed appropriate training. Team members had been briefed. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. But it had not yet had to make any safeguarding referrals.

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

On the day of the inspection the RP worked with a technician, two DAs, and a trainee DA. The trainee DA had worked at the pharmacy for four months. Earlier in her training, she worked alongside the technician for two weeks while she dispensed multi-compartment compliance packs. And she continued to be supported by the technician on a regular basis while under the supervision of the RP. She had also read the relevant compliance pack SOP. Team members attended promptly to people at the counter. They were efficient and calm. And they supported one another, assisting each other when required. The team had the daily workload of prescriptions in hand. And it kept on top of its other responsibilities. Team members assisted each other when needed. And together they dealt with queries promptly.

Team members did not have formal meetings or appraisals about their work performance. But they discussed issues as they worked day-to-day. 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 RP felt supported by the area manager and the SI. And while he had a small number of NHS targets to meet, he felt that he could manage these. And he felt able to make day-to-day professional decisions in the interest of patients.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide an environment which is adequate for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was attached to the local community centre. And it was next to a purpose-built multi-storey health centre. And it shared their car park. The pharmacy had a consultation room and a small retail area with seating for waiting customers. The consultation room provided a place for people to receive pharmacy services or have a private conversation with the pharmacist. And the room was close to the counter and dispensary. The pharmacy kept the consultation room door closed. But not locked. But people did not enter the room without being accompanied by a team member. The pharmacy had a short pharmacy counter with an opening on one side. The opening provided access to the dispensary and the area behind the counter for staff and authorised visitors. The pharmacy’s medicines counter supported a transparent screen to help reduce the risk of spreading viral infections. And the team kept its small range of pharmacy medicines behind the counter.

The pharmacy had enough space for team members to dispense prescriptions including the pharmacy’s multi-compartment compliance packs. It had dispensing worksurfaces on two sides. Which were used for all the pharmacy’s dispensing activities. And it had storage facilities above and below the worksurfaces. It also had a full height shelving unit running along its centre, which provided storage space on both sides. And a further run of full height shelving on its remaining wall. The pharmacy had a cleaning routine. And it kept its worksurfaces tidy and organised. It cleaned its work surfaces and equipment regularly. Team members also cleaned floors regularly and kept them tidy. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines. The pharmacy did not have its own staff facilities. But it used the facilities made available to them by the community centre.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally ensures that all its medicines are stored correctly and safely.

Inspector's evidence

The pharmacy received most of its prescriptions from the health centre. Which had two GP practices, a dental practice, a physiotherapy practice and a district nurse service. The pharmacy was on a single storey at ground level. And it had a doorway which provided step-free entry. Its small customer area was free of unnecessary obstacles, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. And it had information on its windows promoting its services. The team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It also supplied medicines against private prescriptions, some of which came from private online prescribing services.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. The trainee DA processed the prescriptions for the compliance packs, with the oversight of her fully trained colleagues. Completed compliance packs had been labelled with a description of each medicine, including colour and shape, to help people to identify them. While the pharmacy supplied patient information leaflets (PILs) with new medicines it did not supply them with regular repeat medicines. And so, people may not have all the necessary information about their medicines to help them to take their medicines properly. The inspector and the RP agreed that it was important to ensure that people had all the information they needed about their medicines. The RP gave people advice on a range of matters. And he would give appropriate advice to anyone taking higher-risk medicines. The pharmacy 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 RP understood the need to counsel people when supplying the medicine to ensure that they were aware of the risks associated with it. And to ensure they were on a pregnancy prevention programme as appropriate. The RP also provided warning cards and information leaflets with each supply. And he was aware of recent changes in the law about supplying valproate medicines in their original packs. The pharmacy offered the recently introduced NHS Pharmacy First service. This allowed people to access medicines for seven common conditions after an appropriate consultation with the pharmacist. And without having to see a prescriber. The pharmacy had received referrals from its local GP surgeries for the service. And it had also had requests directly from people. The pharmacist had the appropriate protocols to follow. And he kept the necessary records for each supply. In describing the service it was clear that he understood its limitations and when to refer people to an alternative health professional.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines, appropriately. And stock on the shelves was tidy and organised. But some medicines had not been placed back into stock in their original packs. This

meant that they were not stored in packs containing all the required manufacturer's information. And while this did not present a high risk of error, it may mean that the medicines could be missed if subject to a recall or an expiry date check. The RP agreed that the team should review its understanding of the procedures to follow when putting medicines back into stock after dispensing. 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 stored its CD and fridge items appropriately. And it 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. But the RP agreed that checks for recalls, and safety alerts should be made more frequently. 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. And they had a time-out function to ensure they did not remain accessible when unattended for any length of time. Team members had their own smart cards which they shared occasionally. The inspector and team members discussed the importance of using their own smart cards, with their photographs showing. And they agreed that this was necessary to ensure that they each had the appropriate level of access to records for their job roles. And to maintain an accurate audit trail. 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.