General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gee Pharm, 36 Plumstead Common Road, LONDON, SE18 3TN

Pharmacy reference: 1040907

Type of pharmacy: Community

Date of inspection: 07/06/2023

Pharmacy context

The pharmacy is situated in a parade of shops in a residential area. As well as dispensing NHS prescriptions the pharmacy provides seasonal flu vaccinations, the New Medicine Service (NMS) and offers a delivery 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's working practices are generally safe and effective. The pharmacy mainly keeps the records it needs to by law so that medicines are supplied safely and legally. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members respond appropriately when mistakes happen during the dispensing process. But team members do not routinely make records of dispensing mistakes, and this could make it harder for them to learn from these events and to make the pharmacy's services safer.

Inspector's evidence

A set of standard operating procedures (SOPs) were available. There was no indication of when these had been implemented or reviewed, although they had been signed by the owner and all team members in 2021.

Dispensing mistakes which were identified before the medicine was handed out (near misses), were brought to the attention of the team members who said they were discussed with them and then recorded on a log. However, there was no evidence of near misses being recorded since 2021. Team members agreed that there had been near misses since 2021. In the past sertraline 50mg and 100mg tablets had been separated on the shelves to avoid picking errors. Mistakes where the medicine was handed to a person (dispensing errors), were brought to the attention of the pharmacist who would then investigate and speak to the person. Team members described a recent incident where someone was supplied with the wrong strength of Ozempic. The pharmacist had spoken to the person involved, notified the GP and rectified the error. However, team members said no record had been made of this error. As a result of the incident, team members now double-checked items they had picked before labelling and carried out a check of their work before handing to the RP for an accuracy check.

A number of incorrect notices about the responsible pharmacist (RP) on duty were initially displayed; the correct notice was displayed during the course of the inspection. 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. There was a complaint procedure and team members referred complaints to the pharmacist.

Records about private prescriptions, unlicensed medicines dispensed, controlled drug (CD) registers and RP records were generally well maintained. There was one missed entry in the RP register. Emergency supply records did not always have a reason for supply recorded. CDs that people had returned were recorded in a register as they were received. A random check of a CD medicine quantity complied with the balance recorded in the register.

Assembled prescriptions were stored in the dispensary. Team members were initially unsure if they had completed any specific training about patient confidentiality or information governance but when questioned further were able to say they had read SOPs and described what actions they would take to protect people's information. Team members who accessed NHS systems had smartcards. The RP had access to Summary Care Records (SCR); consent to access these was gained verbally.

The RP had completed level two safeguarding training and team members had completed safeguarding training on the NHS eLearning for healthcare (e-LfH). Team members were aware of where the details were for the local safeguarding boards and were able to describe the steps, they would take in the event that they had concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to dispense and supply its medicines safely. But there is no structured framework for ongoing training. This could make it harder for the team members to keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the RP (a locum pharmacist), a pharmacy technician and two trained dispensers. A new team member who was covering the counter had started the week before the inspection and did not sell any medicines without referring to the RP or other colleagues. The owner who provided regular pharmacist cover was away at the time of the inspection.

Staff performance was managed informally. Pharmacists provided team members with ongoing verbal feedback. Team members felt able to raise concerns and feedback to the owner. The team discussed things as they came up but held meetings from time to time. The last meeting had covered the new service as part of which blood pressure checks were carried out for those over the age of 40 years, It had also covered the New Medicine Service and other services provided by the pharmacy.

Team members counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment and would refer to the pharmacist if they were unsure. They were aware of the maximum quantities of some medicines that could be sold over the counter.

To keep up-to-date, team members were briefed by the pharmacist with information. Team members could not recall any recent training they had completed. There were no targets set for pharmacists.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area. The pharmacy premises are aged, and the team could do more to ensure that it is kept organised and presentable.

Inspector's evidence

The dispensary was located at the back of the shop. Pharmacy-only medicines were stored behind a medicines counter. There was enough work and storage space, but some workbenches were cluttered. Fittings had not been updated for some time; this detracted from the overall appearance of the pharmacy. A clean sink, with hot and cold running water, was used for preparing medicines. The room temperature and lighting were suitable for providing pharmacy services. A storage room/office was located in the basement, but this was cluttered and disorganised. The premises were secure.

A consultation room was available for private conversations and services. This was only accessible from behind the medicines counter. The room smelt strongly of food and there was food on the bench. This did not present a professional image; the RP said he was having his lunch and there was not much place for him to have it elsewhere. People had to walk through a hallway to reach the consultation room, past some prescription only medicines (POMs). The team members said these were secured when people were taken into the room and people were accompanied by a member of staff.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. People can access the pharmacy's services. It orders its medicines from reputable sources and largely manages them properly. And it takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. However, the way in which the pharmacy labels multiple packs of the same medicines for people could mean that people are left without dosage instructions and may not know how to take their medicines properly.

Inspector's evidence

Access into the pharmacy was via a small step; members of the team helped people with wheelchairs into the premises. A prescription delivery service was also available. There was a range of posters on display advertising pharmacy services. The pharmacy could produce large print labels if needed. The RP would use a quiet area in the shop to hold private conversations if the person could not access the consultation room. Some members of the team were multilingual and translated for people who did not speak English well. They also used an online translating service if necessary. Team members described how they tried to get people's preferred brands of medicines for them, where possible.

Most prescriptions were received by the pharmacy electronically. Prescriptions were downloaded, labelled and assembled by the dispensers and checked by the RP. It was rare that the RP had to self-check. It was seen that where someone had been prescribed multiple packs of the same medicine, the team sellotaped the packs together and attached one dispensing label. This meant that if the top pack was discarded, it was possible that the person would not have any dosage instructions available. Baskets were used to separate different people's medicines during the dispensing process. Dispensed and checked-by boxes were available on the dispensing labels. But these were not routinely initialled by the team to help maintain an audit trail. This could make it harder for the pharmacy to investigate who was involved in the dispensing process if there was a dispensing error.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. Additional checks were carried out when people collected most medicines which required ongoing monitoring. INR levels were said to be checked routinely but these were not recorded.

Multi-compartment compliance packs were prepared in a designated area. When prescriptions were received these were checked against previous records. The dispenser then collected the stock and asked the RP to check this before preparing the packs. The pharmacy used a diary and recorded when a pack had been delivered or collected. Individual record sheets were available for each person on the service, and these had a list of all the person's medication, and any changes were recorded on these. The pharmacy received a phone call when someone was admitted into hospital. New packs were prepared once changes had been confirmed with the GP. Assembled packs seen were labelled with product details and mandatory warnings. Information leaflets were supplied monthly.

Deliveries of medicines to people's home were carried out by a designated driver. Signatures were obtained when CDs were delivered. If someone was not home, medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. Medicines were organised on shelves in a tidy manner. Fridge temperatures were monitored daily and recorded. Records seen showed that the temperatures were within the required range for storing temperature-sensitive medicines. CDs were held securely. Expiry-date checks were said to be carried out by the team; the date-checking matrix could not be located. A date-expired medicine was found on the shelves checked; this had been marked as short dated. Drug recalls were received via email, which team members had access to. These were brought to the attention of the RP who checked and actioned them.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. However, it could do more to ensure equipment is cleaned and fit for purpose.

Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. Equipment was mainly clean and ready for use. A tablet counting machine was available; this had a thick film of tablet dust within the machine and tray and did not appear to have been cleaned for some time. Team members said the machine was cleaned before each use. No calibration tests had been carried out on the machine and team members provided an assurance that they would check manufacturer's requirements. A fridge of adequate size and a legally compliant CD cabinet were available. Up-to-date reference sources were available including access to the internet.

The pharmacy's computers were password protected and screens faced away from people using the pharmacy. Confidential paperwork and dispensing labels were being kept with waste medicines. Team members explained the shredder was broken and they planned to sort out the waste once a new shredder had been brought.

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.