General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gees Chemist, 27-29 Warwick Way, LONDON, SW1V 1QT

Pharmacy reference: 1041006

Type of pharmacy: Community

Date of inspection: 07/12/2022

Pharmacy context

This busy independent community pharmacy is situated alongside other local shops close to Victoria station in central London. People who visit the pharmacy usually live or work locally, although some of its customers are tourists. The pharmacy dispenses NHS and private prescriptions, and it provides a number of other NHS funded services including flu vaccinations and smoking cessation services. It sells over the counter medicines (OTC), and it also offers some private services including travel vaccinations, strep-A testing, a walk-in minor ailment clinic and ear wax removal.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 generally manages the risks associated with its services and the pharmacy team completes the records that it needs to by law. Team members are clear about their roles and responsibilities, and they keep people's private information safe. Team members understand how they can help to protect the welfare of vulnerable people. But the pharmacy could do more to make sure it has formal risk assessments, procedures and policies in place, so it can demonstrate how it operates and manages services safely.

Inspector's evidence

The pharmacy was one of two pharmacies owned by the same company. The two pharmacies worked closely together and were located in very close proximity. The pharmacy used standard operating procedures (SOPs) based on commercial templates. Current SOP versions and staff training records were not available so the pharmacy could not clearly demonstrate SOPs had been adopted or that staff had received formal training on them. The pharmacist explained the high staff turnover and continued workload pressure meant the team had not had an opportunity to update the SOPs, but a review was planned in February 2023. The team members worked under the supervision of the pharmacist, and they worked within the limitations of their roles. A responsible pharmacist (RP) noticed was displayed identifying the pharmacist on duty.

The pharmacy had risk management processes in place relating to the dispensing operation. Dispensing labels included an audit trail identifying the team members involved in the assembly process and the pharmacist responsible for the supply. Near misses and incidents were recorded and discussed with the team so learning points could be identified and shared. The pharmacist explained how they had sometimes relocated stock in the dispensary to prevent picking errors and the team had discussed how to best manage the space in the dispensary to minimise the risk of prescriptions becoming mixed up.

The pharmacist explained how she considered some of the risks before introducing a new service, such as the walk-in minor ailment clinic. This service was provided by the pharmacist who was a qualified prescriber. She explained how she limited the service to treating adults for acute ear, nose and throat (ENT) infections, and minor skin conditions or infections which were in the scope of her practice. All consultations were conducted in person and a series of diagnostic aids were used as part of the clinical assessment. The pharmacist prescriber explained how she followed NICE guidelines and antibiotic stewardship when issuing prescriptions. A second pharmacist usually dispensed any resulting prescriptions to enable a second clinical check. And the pharmacist prescriber usually followed up with the patient a few days after the initial consultation. The pharmacy had not developed a formal risk assessment or prescribing policy describing the scope or limitations of the service, or how risks were managed and mitigated. And as the service was relatively new and low level, the pharmacy had not completed a clinical audit of the service.

The pharmacy had a complaints procedure. This was promoted in the pharmacy's practice leaflet. Google reviews were also monitored for feedback. The pharmacist explained most concerns were resolved informally, and how the pharmacy had many established many loyal customers.

The pharmacy had professional indemnity insurance with a recognised provider. The pharmacist confirmed this covered all services including the prescribing service. Prescription supplies were recorded on a patient medication record system (PMR), and the pharmacy maintained all the legally required records. Records checked were generally in order although private prescription records occasionally did not include the prescriber's details. The pharmacy had electronic controlled drug (CD) registers. Daily methadone balance checks were completed. Other running balances were checked when supplies were made, and a single balance check matched the amount in the CD cabinet. But full CD audits were not completed regularly. The prescriber kept clinical notes relating to each consultation to show how prescribing decisions were made. Supplies of medicines made in accordance with patient group directions (PGDs) were recorded and reported to the patient's usual doctor if appropriate. Supplies of unlicensed medicines were also recorded appropriately.

A medicines counter assistant (MCA) confirmed they had completed training on data protection and confidentiality. Confidential material was stored securely, and confidential waste was segregated so it could be disposed of safely. The pharmacist had completed level 2 safeguarding training. Team members understood what safeguarding meant and knew to report any concerns about potentially vulnerable people to the pharmacist. They were due to complete an NHS learning module on safeguarding. The pharmacy had a chaperone policy and a notice explaining this was displayed in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and the services that it provides. Team members have the right qualifications for their roles. But the pharmacy does not have a formal staff training and development programme, so team members may develop gaps in their skills and knowledge.

Inspector's evidence

At the time of the inspection the pharmacist (RP) was supported by a pharmacy technician, a dispenser, a foundation pharmacist and an MCA. The pharmacist acted as the pharmacy manager. She was experienced and had worked at the pharmacy for a number of years. She had qualified as a pharmacist prescriber earlier in the year and had worked with a local GP practice specialising in acute minor ailments during her course. Her medical supervisor provided ongoing professional support. The pharmacist was also accredited to provide PGD services and the ear wax removal service.

The MCA had only recently started working at the pharmacy and was enrolled on a course. The dispenser confirmed she had completed her accredited training. A file contained some certificates showing what additional training some of the team members had completed. But the pharmacy did not have formal training records showing what training each individual team member had completed. And the pharmacy did not have a formal appraisal process.

The team worked well together and had a good rapport with people using the pharmacy. The footfall was constant and there was a slight backlog of prescriptions waiting to be checked. The pharmacist said the backlog was unusual and she explained it was because she had recently returned from leave, which meant some tasks such as the end of the month administration process had been completed later than usual. Holidays were planned according to a rota. The team members worked flexibly between the two pharmacies and so cover for unexpected absences was usually available if needed. The superintendent (SI) provided flexible cover and undertook RP duties if one of the regular pharmacists was absent, and the pharmacy had continued to trade throughout the pandemic without having to close.

The pharmacist felt supported in her role and able to exercise her professional judgment. And the pharmacy team were not set any targets or offered incentives relating to pharmacy services. The team could speak directly to one of the regular pharmacists or SI if they had an issue or concern.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for people to receive healthcare services. It has consultation facilities that enables it to provide members of the public with the opportunity to receive services in private and have confidential conversations.

Inspector's evidence

The pharmacy was situated in traditional retail unit. It was bright, suitably maintained and reasonably secure. The retail area was small. A counter restricted access to an open-plan dispensary which had around two metres of bench space. This was small considering the volume of dispensing but there was additional dispensing space in the basement which was used for assembly of compliance packs.

The layout meant there was some potential for conversations to be overheard at the counter if more than one person was waiting, but the team could use a small consultation room next to the dispensary which was accessible from the retail area. The room was equipped with a desk and two chairs, and it had a small sink and a fridge used to store vaccines. Stairs led to a basement which had additional stock rooms, staff facilities, and two additional consultation rooms; one was used for the ear micro suction service and the other by a third-party counselling service.

The pharmacy was reasonably clean, but the main dispensary was cluttered and untidy due to the lack of space. This detracted from the professional image and meant the working environment could be challenging.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a wide range of healthcare services which are generally well managed and easy for people to access. The pharmacy team members give healthcare advice and support to people in the community. The pharmacy sources, stores and supplies medicines safely. And it carries out appropriate checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy operated Monday to Friday 9am to 7pm and Saturday 9am to 6pm. Services were promoted in the pharmacy and on the website www.geeschemist.net. The website included the pharmacy's contact details and people could use it to request a repeat prescription or book an appointment for one of the services. The pharmacy had an automated door at the entrance, so access was unrestricted. A home delivery service was available for people who could not easily come to collect their prescription in person and there was an associated audit trail. The ear wax removal service was provided from one of the consultation rooms in the basement which meant it was prohibitive for people with mobility difficulties, but they were informed of this when booking. The team could signpost to other services available locally.

The pharmacy dispensed a high volume of prescriptions. As the dispensary was small the workflow was compromised but there was a separate checking area. The dispensary shelves were reasonably well organised. Dispensed by and checked by boxes on dispensary labels were completes. Baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available. Substance misuse instalments were prepared the evening before they were due to help spread the workload. The pharmacy team had a good relationship with local surgeries and drug treatment services which helped when resolving issues.

Prescriptions were highlighted when counselling was required, and the pharmacist was aware which high-risk medicines she should target for extra checks and counselling. The pharmacist was aware of the valproate pregnancy prevention programme. She was aware of one patient in the at-risk group who received their medication in a compliance pack. Care cards were supplied with the packs which were issued weekly. The pharmacist confirmed previous discussions with the patient about pregnancy prevention, but she had not recently checked if they had an annual review with their specialist or GP. And counselling had not been noted their patient medication record (PMR).

The pharmacy supplied a large number of people with multi-compartment compliance packs. These were well managed with an audit trail for changes to medication. Medicine descriptions were usually included on the packaging to enable identification of the individual medicines. Packaging leaflets were mostly included so people were able to easily access additional information about their medicines. Disposable equipment was used. Most requests for packs were initiated by the person's doctor and the pharmacy did not usually undertake a formal assessment to determine whether a compliance pack was the most suitable option.

The pharmacist supplied a range of prescription only medicines (POMs) under patient group directions (PGDs) including travel vaccinations. She also provided the strep-A testing, the ear wax removal service

and the walk-in minor ailment clinic. The pharmacy had decided to set up the ear wax removal service when the local surgery stopped offering this option and the pharmacist had informed the surgery team of this.

The minor ailment clinic was developed in response to local need as many people found it difficult to get a GP appointment. Around three or four consultations were requested each week. The pharmacist used a range of diagnostic equipment and criteria to make a clinical judgement. For example, she used strep A and covid tests, and completed physical examinations when people presented with ENT conditions. She sometimes accessed Summary Care records (SCR) if people consented to verify any ongoing medical conditions or regular medication. Consultation notes identified prescribing decisions including when a treatment had been refused. One record included a referral letter sent to the person's GP which suggested further investigation because of the symptoms they were experiencing. The pharmacist usually completed a follow up telephone call with the patient to check their progress, but she did not routinely inform the person's GP when a treatment had been provided, to ensure continuity of their care. However, she agreed to consider this option moving forward.

The MCA understood which medicines could be sold in the presence and absence of a pharmacist and knew that codeine containing medicines could be misused. The pharmacist could easily supervise and intervene with OTC sales. The pharmacy only supplied codeine linctus on prescriptions as the pharmacist knew this could be abused. She had recently intercepted and refused to supply a recent forged prescription for codeine linctus

Recognised licensed wholesalers were used to obtain stock medicines. Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out. Expired and unwanted medicines were segregated and placed in designated bins for disposal by recognised contractors. CDs were stored in appropriately secured cabinets. Obsolete CDS were segregated in the cabinets, and patient returned CDs and their destructions were documented.

Alerts and recalls were received via email messages from the Medicines & Healthcare products Regulatory Agency (MHRA). These were read and acted on by a member of the pharmacy team. Any affected stock was quarantined and returned to wholesalers or manufacturers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has equipment and facilities it needs for the services it provides. The team members maintain the equipment so that it is safe, and they use it in a way that protects privacy.

Inspector's evidence

The pharmacy had access to reference sources, including the BNF and the children's BNF. Internet access was available. A range of clean, crown stamped measures were available for dispensing purposes. Separate measures were used for the preparation of methadone, and the pharmacy had equipment for counting loose tablets and capsules as well as disposable containers and boxes for dispensing medicines. The pharmacy team had access to personal protective equipment and sundries necessary for the provision of vaccination services such as anaphylaxis equipment and sharps bins. Equipment used for other services included a blood pressure meter, oximeter, an otoscope, a stethoscope, a thermometer and a portable microsuction device for the ear wax service.

There were two medical fridges for storing medicines and storage temperatures were monitored daily to make sure they were within a suitable range. Patient records were stored electronically. The pharmacy had computer terminals in the dispensary and an additional one in the consultation room, which was sufficient for the volume and nature of the services. Computer screens could not be viewed by members of the public. Access to computer systems was password protected and team members used individual smartcards to access NHS data. The pharmacy had a dedicated telephone line. All electrical equipment appeared to be in working order.

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.