General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Amadis Chemist, 107 Abbey Street, Bermondsey, LONDON, SE1 3NP

Pharmacy reference: 1040710

Type of pharmacy: Community

Date of inspection: 13/06/2019

Pharmacy context

This is a community pharmacy situated within a parade of shops. It serves a diverse local community. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines. It also supplies medicines in multi-compartment compliance trays to help people take their medicines.

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 appropriately. But the pharmacy does not always record mistakes that occur during the dispensing process. This may mean that the pharmacist is less able to spot patterns in mistakes and they may not always understand how to prevent similar mistakes in the future. The pharmacy largely keeps the records it needs to by law, but these are not always available for inspection. It generally manages and protects confidential information well.

Inspector's evidence

Standard operating procedures (SOPs) were in place but these were overdue a review. The trainee medicine counter assistant (MCA) said she had read some, but not all SOPs relevant to her role. Audit trails were not always maintained to confirm that current members of the team had read and understood the SOPs. The superintendent pharmacist (SI) said he would be reviewing the SOPs and asking all current members of the team to re-read the relevant ones.

The SI said he tried to assemble multi-compartment compliance trays during quieter periods. He left assembled trays aside and then returned to accuracy check them after a short mental break. This helped reduce the chance of errors. The SI was observed personally handing out dispensed medicines; he said that this was routine practice and helped him confirm the medicines he had dispensed with people. He informed people if he was using a different brand or if the packaging of the medicine had changed. This helped reduce confusion.

A near miss log was displayed at the dispensary but near misses were not routinely recorded. The log had last been used in 2016 and the SI accepted that some near misses had not been captured. He described making some changes to help reduce errors, for example, bendroflumethiazide 2.5mg and 5mg tablets, and Spiolto and Spiriva Respimat had been separated on the shelves.

The SI said there had been one dispensing error in April 2019, but he had not documented it. He said he had identified the error after checking prescriptions at the end of the day, as part of his normal routine, and realising he had dispensed the incorrect strength of a medicine. He had then contacted the person and informed them of the error. An SOP on how to handle dispensing incidents was in place but the SI was not entirely sure of where he would document these. He said he would start documenting dispensing errors on the electronic patient medication record (PMR) system.

An out-of-date indemnity and public liability insurance certificate was displayed at the pharmacy. The SI contacted the insurance provider during the inspection and they confirmed that the pharmacy had in-date cover. The correct responsible pharmacist (RP) sign was displayed in the retail area and samples of the RP register examined were in order. All necessary records, including private prescription and emergency supply records, were kept. They were mostly in order, but prescriber details were not always accurate for some private prescription entries examined. ‘Specials’ records for unlicensed medicines were completed in line with MHRA requirements.

Controlled drug (CD) running balances were maintained but it was not possible to check all CD registers at the time of inspection. Random balance checks of two CDs agreed with the recorded balance but one

did not. The SI investigated the discrepancy following the inspection and updated the CD registers accordingly. Expired medicines were stored in labelled, clear plastic bags, separate from in-date stock.

The trainee MCA said she would refer any complaints to the SI. People were able to provide feedback via annual community pharmacy patient questionnaires (CPPQ) and the NHS website. A number of positive reviews were seen on the NHS website.

The SI and trainee MCA had both read material on the General Data Protection Regulation (GDPR). Confidential waste was collected in a basket and shredded at the pharmacy. Computers were password-protected and access to the PMR system was via NHS smartcards. One person, waiting for their medicine, was seen entering the dispensary and standing next to bags of medicines awaiting collection. These had prescriptions attached to them and people's personal information was visible to the person. The SI said he would remind people to wait in the retail area.

The pharmacist had completed a safeguarding module from the Centre of Pharmacy Postgraduate Education. The trainee MCA had been briefed about the subject and had attended a training workshop with the pharmacist several years ago. She was aware of the signs to look out for and how to raise concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

Members of the team are enrolled onto accredited courses and are provided with training resources to help keep their skills and knowledge up to date. The SI reviews staffing levels and makes changes to ensure there is sufficient cover for the services provided.

Inspector's evidence

During the inspection there was the SI and a trainee MCA. The pharmacy also employed another part-time trainee MCA. The SI normally booked a locum pharmacist once a week to help him catch up with administrative tasks but had recently found that was not enough and had started booking cover for two days a week. There was currently no backlog for the dispensing service.

Both the SI and trainee MCA had good rapport with people and knew most of them on a first-name basis. The trainee MCA said that the SI was very friendly and caring, always going out of his way to help people. The trainee MCA covered the medicines counter but was, at times, involved in putting dispensary stock away. The SI said that she would not be involved in dispensary tasks in the future, unless she was suitably trained. She asked the WWHAM questions before selling pharmacy-only medicines (P-medicines) and referred anyone requesting painkillers to the pharmacist. She could name products which were liable to abuse and referred regular requests of these to the pharmacist. She said she would not sell P-medicines or hand out dispensed medicines in the absence of the RP.

The trainee MCA completed her course material at home. She said she was able to ask the SI for help if needed and she discussed her progress with him once a week. She had access to additional training material, for example, counter booklets from wholesalers and information booklets provided to her by company representatives. She was in the process of reading a booklet on pain relief and had recently learnt additional information about a cough remedy.

Performance was discussed informally. The trainee MCA said the SI gave her feedback on a regular basis and she was happy to raise concerns with him. Targets were not set for the trainee MCAs.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally suitable for the pharmacy's services.

Inspector's evidence

This was a relatively small pharmacy. There was limited work and storage space, but the dispensary was generally clean and organised. P-medicines were stored behind a small counter in the retail area and were not accessible to people. A small hatch was fitted between the dispensary and the medicines counter. This allowed the pharmacist to supervise the trainee MCAs.

Some prescription-only medicines were stored at the entrance of the dispensary, near the retail area. They were accessible to people waiting near the dispensary. The SI said he would move these to ensure they were not easily accessible.

A small, clearly signposted consultation room was available for services and was suitable for private conversations. The room was generally tidy and was kept locked when not in use. A small sink, with hot and cold running water, was available for the preparation of medicines. The room temperature and lighting were suitable for the provision of pharmacy services. A storage room was located behind the dispensary, but it was messy. The premises were secure.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy generally organises its services well and provides them safely. But people taking some higher-risk medicines might not always get all the information they need to take their medicines safely. The pharmacy generally manages its medicines well to make sure that they are safe for people to use. But it could improve how it manages date expired medicines.

Inspector's evidence

Access into the pharmacy was step free. The trainee MCA was observed helping a customer with a wheelchair into the premises. She said that the SI would take people with wheelchairs to a quiet corner if they needed additional privacy as the consultation room was too small for wheelchairs. There was one chair available in the retail area for people wanting to wait for a service.

A small range of information leaflets was displayed in the retail area for people. The SI was observed personally handing out dispensed medicines and providing additional advice, for example, on how to take the medicine. Dispensing audit trails were generally maintained; the SI signed the 'dispensed by' and 'checked by' boxes on medicines labels to help identify who was involved in both tasks. Amber medicine bottles were seen to be reused for CD instalments as several labels were placed on top of each other. This was unhygienic and could increase the risk of contamination. The SI said he would use new bottles for each instalment.

The SI said he had seen the valproate guidance but had not yet read it. He said he would advise women in the 'at-risk' group to discuss their medication with their prescriber if they were planning a pregnancy. Information cards and additional warning stickers were not available to hand. The SI said he would order additional supplies of these.

The SI did not routinely check if people taking some higher-risk medicines, such as lithium, were being monitored. He said he confirmed if people taking warfarin and methotrexate were attending their blood test appointments, but INR levels not recorded for reference. He did not routinely provide dietary advice or counselling on signs of toxicity to these people.

Prescriptions for people receiving their medicines in multi-compartment compliance trays were managed by the GP surgery. The pharmacy would contact the person or their GP if their prescription was not issued, for example, to check if they had been hospitalised. People were organised over a four-week cycle; and a list was used to check if prescriptions had been issued by the prescriber. Prescriptions were checked against the PMR once they were received; any changes were recorded on the PMR. Medicine descriptions were provided on the labels to help people identify their medicines and patient information leaflets were seen to be supplied.

The system and equipment required to meet the Falsified Medicines Directive were in place, but the SI had not received any training. He said he would find out about completing some training on the system and the procedures that should be followed. The SI said he conducted expiry date checks at least twice a year, but records were not maintained to help keep track of these checks. Medicines with short 'use-by' dates were stored in a separate basket but some medicines expiring in July 2019 were found on the

shelves and had not been marked in any way. The SI said he rarely dispensed medicines without checking their expiry date. Several packs of expired medicines were found in the fridge or on the shelves.

Fridge temperatures were checked and recorded daily; these were kept within the recommended range of 2 to 8 degrees Celsius. The pharmacist said that drug alerts and recalls were received from wholesalers. Audit trails of action taken in response to these alerts were not maintained. This may make it harder for the pharmacy to show that the stock is safe and fit for purpose. He was not aware of the recent alerts for paracetamol tablets and co-amoxiclav powder; stock of these were not found at the pharmacy at the time of inspection. The SI had signed onto the MHRA's email subscription service during the inspection to help ensure that he received alerts and recalls in a timely manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

There were two clean glass measures. One clean counting triangle was also available. The SI said cytotoxic medicines were normally received in foil blisters and not as loose tablets. He said he would clean the triangle before and after use with a cytotoxic medicine, to help prevent the chance of cross-contamination.

The fridge was clean and suitable for the storage of medicines. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several up-to-date reference sources.

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.