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: 12/09/2022

Pharmacy context

This pharmacy is located within a parade of shops in Southeast London. The pharmacy serves people of all age ranges and receives most of its prescriptions electronically. It provides the New Medicine Service. It also provides medication in multi-compartment compliance packs to people who live in their own homes and need help managing their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy does not always adequately manage the risks associated with its services.
		1.6	Standard not met	The pharmacy's recording keeping for its controlled drugs is poor. And it does not have robust systems to keep its controlled drug registers up to date.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is disorganised and cluttered. It has limited clear space to be able to dispense and check medicines safely. There are items on the dispensary floor which are tripping hazards for staff. And the consultation room is untidy.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy doesn't always store its medicines securely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy does not adequately manage all of the risks associated with its services. It does not always keep its records up to date and accurate, particularly its controlled drug records. And areas of the pharmacy are disorganised and untidy, which increases the risk of a dispensing mistake happening. Team members protect people's personal information appropriately. But they don't always record mistakes that happen during the dispensing process. So, they might be missing opportunities to learn and make the services safer.

Inspector's evidence

The pharmacy had stopped some services, such as blood pressure checks, since the Covid-19 pandemic. It had become busier, but this was gradual and team members said they had been able to manage the additional workload. The pharmacy had introduced some measures to help reduce the likelihood of infection, for example, limiting the number of people in at the same time and reminding people about safe distancing measures. The trainee dispenser said that the premises and equipment were disinfected throughout the day. Personal protective equipment was available for the team.

The dispensary was extremely disorganised. Workbenches were cluttered and there was very little clear space to dispense and check prescriptions. Bags of medicines awaiting collection were stored on the dispensary floor. Taken together, this increased the risks to staff and increased the risk of a dispensing mistake happening. The superintendent pharmacist (SI) said he had recently joined a pharmacy group for additional support. He had been visited by a member of their professional standards team who had provided him with feedback on areas for improvement. The SI said he was trying to work through a list of actions that he had been provided with by the pharmacy group. He accepted that he had a backlog of tasks, such as reviewing the pharmacy's standard operating procedures (SOPs) and updating records. The pharmacy was up to date with its dispensing tasks.

The SI had ordered a new batch of SOPs from the pharmacy group. The current SOPs had been prepared in 2016 and last reviewed in 2018. They had only been signed by the SI. The trainee dispenser, who had been working at the pharmacy on and off for the past ten years, had not signed the SOPs relevant to her role, for example, the sale of medicines SOP, but she said that she had read them.

The pharmacy team did not routinely document dispensing mistakes which were identified before the medicine was handed to a person (near misses). A near miss log which was displayed in the dispensary had not been updated since June 2019. A new log had been put in place by the pharmacy team but only had one entry from July 2022. The SI said he had struggled to book locum pharmacists recently but was planning on recording and reviewing the near miss log in the future. He added that the pharmacy did not have many errors as he always showed the person their medication when handing it out. Dispensing mistakes which reached people, or dispensing errors, were not always recorded. The SI described a recent mistake where the pharmacy had supplied amlodipine 10mg tablets instead of amlodipine 5mg tablets. The SI had visited the person's home after identifying the error and had replaced the incorrect medicine. He said he would document dispensing mistakes in the future.

An out-of-date Indemnity insurance certificate was displayed at the pharmacy. The SI sent a copy of the up-to-date certificate following the inspection. A correct responsible pharmacist (RP) sign was displayed

in the retail area. Samples of the RP record were generally well maintained. Other records required for the safe provision of pharmacy services were generally completed in line with legal requirements, including those for private prescriptions and emergency supplies. The SI said that controlled drug (CD) registers had not been updated for some time. There was evidence that at least one entry from 2020 had not been made, and there were several CDs for which the pharmacy had stock but no corresponding registers.

The pharmacy normally conducted annual patient satisfaction questionnaires but had not done these since the start of the pandemic. People were able to give feedback or raise concerns verbally or online. The pharmacy had 66 positive reviews online.

Team members had completed an online module on protecting people’s confidentiality which also covered the General Data Protection Regulation. The trainee dispenser described ways in which she tried to protect people’s confidentiality, for example, by not speaking loudly to people or shouting out names and personal details. Prescriptions awaiting collection were stored inside dispensary and were not visible to members of the public. Confidential waste shredded at pharmacy and computers were password protected.

The SI and trainee dispenser had both completed face-to-face training on safeguarding at Dulwich Hospital though this was several years ago. The trainee dispenser said that she would raise concerns to the SI, but she was not aware of the local safeguarding team. She said that she would complete refresher training.

Principle 2 - Staffing ✔ Standards met

Summary findings

Overall, the pharmacy has sufficient team members to manage its workload but there is a backlog of administrative tasks. Team members complete some ongoing training to help keep their skills and knowledge up to date.

Inspector's evidence

During the inspection there was the SI, who was the regular pharmacist, and a trainee dispenser. A trainee medicines counter assistant, also helped cover some shifts when needed. The trainee dispenser mainly covered the medicines counter but had been enrolled onto a dispensing course in June 2022. She had also been enrolled onto a Healthy Living Champion course and completed material for both courses at work and at home. She said she discussed her progress and learnings with the SI on a weekly basis. Team members had good rapport with people and knew the majority of people on a first-name basis. The trainee dispenser was observed assisting people in and out of the pharmacy and the SI was observed personally handing dispensed medicines to people and counselling them on how to take them. He also spent some time trying to deal with a prescription issue that a person was experiencing with their GP surgery.

The trainee dispenser said that the current team had worked throughout the pandemic and the pharmacy had not experienced staff shortages during the pandemic. The SI said that he had struggled to find regular locum pharmacist cover in order to help him manage the back log of administrative tasks. He had arranged for a locum pharmacist to work one day a week for the next few weeks. The SI had previously relied on two regular locum pharmacists, but they were no longer available.

The trainee dispenser described her responsibilities which included housekeeping, serving customers, taking in prescriptions, and handing out medicines, selling pharmacy-only medicines (P-medicines) and expiry-date checks. She was aware of the RP regulations and described the tasks she could or could not do in the absence of the RP. She said she regularly completed online modules or read material she received from wholesalers, and had had recently read up on hay fever, dermatitis and flu. She was learning about how to identify mental health issues as part of the Healthy Living Champion course and described how she would accommodate people with these conditions. She said that the training had helped her identify symptoms of dementia in a person which she had discussed with their next of kin. The person had since been reviewed by their GP and diagnosed with dementia.

Staff performance was managed informally. The trainee dispenser was happy to raise concerns directly to the SI. Only training targets were set for the trainee dispenser.

Principle 3 - Premises **Standards not all met**

Summary findings

The premises are disorganised, untidy and cluttered, and there are tripping hazards for staff working in the pharmacy. There are unresolved maintenance issues, and there is little free space to safely dispense. The pharmacy has a private area where people can talk with a team member, but this is cluttered and not in a usable state. The premises are otherwise largely suitable for the pharmacy's services, and they are secure from unauthorised access when the pharmacy is closed.

Inspector's evidence

This was a relatively small pharmacy. The retail area was clean and tidy, but the dispensary was extremely disorganised. There was limited workspace and workbenches were cluttered with prescriptions and medicine packs. Medicines awaiting collection were stored on the dispensary floor. There was a narrow corridor to the side of the dispensary which led to a storage room at the back of the premises. There were several boxes and bags stored on the corridor floor which presented tripping hazards for the team. The storage room was cluttered, disorganised and smelt of sewage. The trainee dispenser said that the council had visited the premises a number of times but had not been able to resolve the issue.

A consultation room was available though it was cluttered with boxes to the point that there was no space for people. The entrance to the room was also blocked with delivery boxes. A hatch was fitted between the dispensary and medicines counter so the SI could observe the sale of medicines. The premises were kept secure when the pharmacy was closed.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy does not always store its medicines securely. There are issues with the state of the pharmacy's premises, but otherwise it generally provides its services safely. It orders its medicines from reputable sources and largely stores them appropriately. But it does not always remove expired medications from shelves. This could increase the chance of supplying date-expired medicines. It does not always store its assembled multi-compartment compliance packs appropriately, which may increase the likelihood of mistakes happening.

Inspector's evidence

There was step-free access into the pharmacy. The pharmacy offered a limited range of services which were adequately promoted. The pharmacy's opening hours were displayed on the front door and a poster directing people to NHS111 during closing hours was also displayed. Team members described signposting people to other service providers.

Workbenches were extremely cluttered and there was no clear space to dispense and check on. Dispensed and checked-by boxes were not used by team members to help keep dispensing audit trails. Baskets were used to separate prescriptions and prevent transfer between patients, however, several multi-compartment compliance packs, for various people, were found in one plastic bag on the bench. One of the trays had not been sealed as the SI was awaiting stock, and another pack's backing sheet was loose in the bag. This could increase the risk of mixing people's packs. The SI said that he encouraged people to order their own prescriptions and the pharmacy generally did not order prescriptions on behalf of people. Prescriptions for some people receiving multi-compartment compliance packs were sent automatically by their GP. There was limited space to assemble the packs in the dispensary and prescriptions were not always retained with the packs. The prepared packs were not labelled with product descriptions to help people identify their medicines, and patient information leaflets were not routinely supplied.

The SI was aware of the valproate guidance and described checks he would make when dispensing this medicine to people in the at-risk group. Warning cards were available on the packs that the pharmacy dispensed. He said that he checked if people taking other higher-risk medicines, such as warfarin and methotrexate, were being monitored, and provided additional advice.

The delivery service was limited to vulnerable and housebound people and was carried out by either the SI or the trainee dispenser. The SI said that signatures were obtained to confirm receipt of medicines.

Medicines were obtained from licensed wholesalers but were not always stored tidily. Some prescription-only medicines and P-medicines were not stored securely. The fridge temperature was monitored and recorded daily. The SI said that stock was date checked on a regular basis, but several date-expired medicines were found mixed in with stock and were removed for destruction. Date-checking records were not maintained but the SI had recently introduced a new template which he said would be filled in by the team to help keep track of future checks. The SI said that he checked and actioned MHRA drug alerts and recalls but did not maintain records of action taken. He said that he would document any action taken in response to alerts and recalls in future. Waste medicines were

placed in designated bins, and these were collected by an approved waste contractor. Some medicines returned by people were stored on the shelves in the storage room. The trainee dispenser said that these were yet to be processed.

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

The pharmacy had two glass measures and two tablet counting triangles. There was one fridge in the dispensary though it was packed with stock. The trainee dispenser said the pharmacy was planning on ordering a new fridge. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively.

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.