

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: 28/09/2023

Pharmacy context

This pharmacy is located within a parade of shops in South East London. The pharmacy dispenses both NHS and private prescriptions. And 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	1.2	Standard not met	The pharmacy does not adequately record and review mistakes that are made during the dispensing process. And it does not keep sufficient information related to these mistakes to learn from them. This means it may miss opportunities to improve processes to reduce the risk of similar mistakes happening again.
		1.6	Standard not met	The pharmacy's recording keeping for its controlled drugs is poor. And it does not always have these records available. It does not always make complete records about the private prescriptions it dispenses.
		1.7	Standard not met	The pharmacy does not always adequately protect people's information when providing its services. Pharmacy services are offered in the dispensing area which means access to confidential information is not always restricted.
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 untidy. There is not enough storage space and items left on the floor create a tripping hazard. The consultation room is extremely untidy and not accessible.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not always store its medicines securely. And it does not keep adequate records of temperature checks to confirm appropriate storage conditions are met. Medicines are not always safeguarded from unauthorised access.
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 keep accurate records of mistakes that occur during the dispensing process. And the information to explain what has happened is missing. So, pharmacy team members may miss out on opportunities to learn from these mistakes and improve the processes they follow. The pharmacy does not always keep the records it is required to by law. And it often does not keep accurate or up-to-date records which may make it harder to rely on this information in the future. People's information is not adequately protected when pharmacy team members provide services. But they understand how they can help to protect vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) that had been read and signed by the pharmacy team members towards the end of 2022. The SOPs had not had a formal review since 2016. And some of the SOPs covered services that were no longer provided. The SI had thought that staff signing the SOPs again would be classed as a review. The length of time since the processes were last reviewed could mean they may not reflect the current practices that are followed. The superintendent (SI) said they would review these immediately.

The pharmacy had limited records about mistakes made during the dispensing process that were identified by the pharmacist during a final check, known as near misses. Only a few entries had been made on a near miss log over the past 12 months and they often did not capture the specific actions taken to try to prevent similar mistakes happening again. Some of the entries related to dispensing mistakes which had not been spotted before medicines were supplied to people, known as dispensing errors. An SOP covering the process to follow when a dispensing error is identified was available, but it was not being followed. In these instances, the pharmacy had not recorded sufficient detail to explain what had happened, which members of the team were involved or if any harm came to people receiving the incorrect medicines. This may make it harder to respond to any queries that may arise following the errors. And opportunities for team members to learn from the errors and improve processes may have been missed. The SI said he would review these and record any dispensing errors in greater detail going forwards. Reviews of near misses and errors did not take place, again limiting the opportunities for the team members to learn from these mistakes.

The pharmacy did not always take steps to protect people's data sufficiently. There was no formal procedure detailing how people's data should be protected. And confidentiality agreements were not in place for team members. People requiring a private conversation were often brought to the entrance of the dispensary where prescriptions ready for collection were in view. Prescriptions were also kept in the consultation room and, although some of the glass was frosted, it still allowed visibility of the contents in the room. However, team members explained that they separated waste with people's information and shredded it. They also protected people's privacy by having discrete conversations in the dispensary so that they could not be overheard by others.

An SOP for safeguarding vulnerable people was in place and signed by pharmacy team members at the end of 2022. The trainee dispenser explained what they would do if they identified a safeguarding concern. In this situation they would refer to the pharmacist.

The trainee dispenser was able to identify circumstances when they would refer to the pharmacist. This

included the sales of pharmacy (P) medicines, but the trainee dispenser would ask the relevant questions in the first instance. They were aware of the responsible pharmacist (RP) regulations and what they could not do in the absence of a pharmacist.

The pharmacy had a mechanism for people to provide feedback and a poster was displayed in the retail area telling people about this. People also left google reviews about the service they received; these were generally positive. The SI provided evidence that the pharmacy had professional indemnity insurance in place, to November 2023.

The pharmacy did not always keep the records it needed to by law and several shortfalls were identified relating to records for controlled drugs (CDs). Several CD registers were not available for inspection and therefore checks could not be carried out to confirm the accuracy of these registers against the physical stock being held. Generally, the registers that were available had running balances and completed headings to identify which CD stock the register related to. Checks of the running balance against the physical stock held were infrequent. In some cases, balances were checked over a year apart meaning that any discrepancies could be difficult to resolve. A random selection of physical stock was checked against the recorded balance in the registers that were available during the inspection, and most were found to be correct. There was a handful of prescriptions for CDs that had been handed out to people that were yet to be recorded in the respective registers. This could result in incorrect entries being made making the records inaccurate. CDs that had been returned to the pharmacy by people were recorded in a patient-returns register. Destruction of these CDs were completed in a timely manner.

A wide range of medicines were dispensed against private prescriptions, including CDs and weight loss injections. The records for these prescriptions were kept electronically but these records did not always comply with requirements. Numerous entries were missing the prescriber's details, and, in one case, the patient's address was missing. An RP record was kept electronically and was kept in full over the previous 90 days. The correct RP notice was on display. The pharmacy did not routinely dispense any unlicensed medicines, but the pharmacy team was aware of the record keeping requirements.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy's team members are on training courses to help them with their roles and responsibilities and support is available to them. And the pharmacy has just enough staff to manage the services it provides. But the pharmacy doesn't always manage to keep on top of other housekeeping tasks.

Inspector's evidence

The pharmacy team consisted of a regular pharmacist, who was also the SI, and a trainee dispenser. A locum pharmacist was also present during the inspection. When cover was required for absences, a relief trainee medicine counter assistant was available. The pharmacist generally worked alone in the dispensary and dispensed and checked most prescriptions themselves. They mentioned that they would take a mental break between the dispensing and checking process so that they were able to identify any mistakes that they may have made. The pharmacy team was up to date with its dispensing tasks but some other activities such as record keeping and housekeeping were not always done in a timely manner.

The trainee dispenser was aware of their role and responsibilities. Their main jobs included serving people on the front counter, handing out prescriptions and answering the telephone. They also completed most of the checks for expired stock and cleaning. When asked about the sale of medicines over the counter, they were able to identify medicines considered to be high risk. In this case, they would refer to the pharmacist. An example of a refusal to supply an addictive medicine because of repeated purchases was given. The sale of a medicine was seen to be carried out safely, with the appropriate questions being asked. The trainee dispenser felt well supported by the SI and help was available if they struggled with any aspects of the training course.

Team members did not have formal appraisals, but they felt comfortable raising concerns or providing feedback to the SI at any time. Regular informal conversations took place between the SI and trainee dispenser to discuss their progress on any training courses and to agree what support, if any, was required. Team meetings were also held in an informal manner and were used to talk about what work streams needed prioritising for the day or week.

The pharmacy did not use any incentives or set target to manage the performance of the pharmacy team members. The communication between members of the team was good and this was evident when serving people who came into the pharmacy or responding to queries.

Principle 3 - Premises Standards not all met

Summary findings

Overall, the premises are untidy, disorganised, and cluttered. There is very little space in the dispensary area to work safely and there are tripping hazards which pose a risk to the pharmacy team members. The pharmacy has a consultation room, but it is not used because the room is disorganised and extremely cluttered, making it difficult to enter safely.

Inspector's evidence

The premises were relatively small, and the dispensary did not provide sufficient space to allow for the workload to be organised in a safe manner. As a result, prescriptions had to be stored on the floor, along with medicines that came in from wholesalers. The fixtures and fittings were suitable for storing medicines. A small swing door was used to access the dispensary area which didn't adequately restrict unauthorised access. The same style of door was also used for the pharmacy team to get behind the front counter to serve people. This allowed for P medicines to be easily accessible to people. The SI said he would look for a better way to restrict access.

There was a hatch between the dispensary and retail area which allowed the pharmacist to oversee the sale of medicines and intervene if needed. The retail area was well kept and organised. The premises had a storeroom which was extremely cluttered and untidy. This was being used to store excess stock, including some medicines. The shelving was not clean in some areas and the stock was placed in a disorganised manner. There were several large boxes of supplements on the floor of a narrow walkthrough between the dispensary and the storeroom which posed a tripping hazard to the pharmacy team.

The premises had a consultation room, but it was very cluttered, and the entrance was blocked with boxes of stock medicines, prescriptions waiting to be collected and medicines that had been returned to the pharmacy. So, people could not use it for private conversations. The pharmacist instead spoke to people in the front of the dispensary. This meant people were within easy access to restricted medicines and devices stored on the shelves near to the entrance.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy gets its medicines from licensed sources, but it doesn't always store its medicines appropriately to prevent unauthorised access. It doesn't always separate expired stock from in-date stock. And it doesn't keep a complete record of when it date checks its stock. This could increase the chance of medicines which are not fit for purpose being supplied to people. The pharmacy doesn't always follow its written processes when it provides services to people. So, its team members may not be following best practice. However, the pharmacy supports people who require help taking their medicines by supplying multi-compartment compliance packs.

Inspector's evidence

The entrance to the pharmacy was step free with a manual door leading into the entrance of the retail area. Seats were available for people who wanted to wait to receive a service. The opening hours and services provided were displayed on the entrance door and windows.

The pharmacy got its medicines and devices from several licensed suppliers, but it did not take adequate steps to keep its stock safe from unauthorised access. Deliveries of medicines were left in the retail area under no direct supervision throughout the inspection. And it was possible for people to access medicines in the dispensary.

Medicines were not organised in any way and in some cases kept in different locations. Some of the shelves were untidy which could increase the risk of a mistake happening during the dispensing process. The consultation room contained bags of medicines that were returned to the pharmacy along with medicines that were ready for people to collect. This also increased the risk of dispensing errors. The SI was aware of the actions to take when a MHRA drug recall was received by email but no records of these checks being carried out were made.

The pharmacy had a CD cabinet which was appropriately secured to the wall. The stock inside the cabinet was disorganised and untidy. This could increase the chance of mistakes being made during the dispensing process. Expired stock was not separated appropriately from normal stock. This was placed on the top shelf of the cabinet but not always clearly marked. Amber medicine bottles for the same person were reused for CD instalments; 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.

Medicines that required cold storage conditions were stored across two fridges. The temperatures of both fridges were found to be within the range required but records were not kept in full. A new fridge was installed in March 2023, but daily temperature checks were not being recorded at all. Records for the second fridge were stored electronically; they were found to be in range with no issues over the previous 60 days. The SI explained they would start recording the temperature checks for the new fridge.

Pharmacy team members explained that the expiry dates of medicines and devices were checked on a weekly basis. And they would record short-dated stock in a diary under the month it was due to expire so they could remove it from the shelf. The pharmacy did not routinely make any records when date

checking was completed and therefore an audit trail was not available to show which areas of the premises had been checked. The pharmacy didn't record the date when liquid medicines were opened. An example of this included a bottle of methadone solution which has a shortened shelf life once opened. This could make it harder to assess if the contents were still suitable to supply. And medicines with a short expiry were not highlighted as per the written procedures in place. A random selection of medicines was checked and some were found to be past their expiry date (a split pack of Lantus insulin vials had expired 7/23 and three packs of Phenergan liquid had expired 8/23).

"Dispensed" and "Checked" boxes on dispensing labels were signed so that there was a record of who was involved in the dispensing process though there was evidence found that this was not routinely done when the regular pharmacist was on duty. This went against the written procedures in place. Prescriptions for different people were separated using baskets and the trainee dispenser would add a note if the prescription was needed urgently. This allowed team members to prioritise the workload. Team members would make a note on the prescription if the pharmacist needed to speak to someone about their medicines or offer extra advice.

The pharmacy supplied medicines in multi-compartment compliance packs to people who required additional support to help them take their medicines. The regular pharmacist assembled and checked the packs themselves. A few of the packs were seen to have no "dispensed" and "checked" signatures available which went against the written procedures in place. They did not provide any descriptions of the medicines that were dispensed which may make it harder for people to identify their medicines. Patient information leaflets were provided so people could access additional information about their medicines should they wish. Some packs had been assembled in advance of the prescription being issued by the prescriber to help manage the workload. The labels and backing sheets were missing for these packs. The risks of doing this were discussed with the SI.

The pharmacist was aware of the need to provide additional counselling advice when supplying people with prescriptions for sodium valproate. They explained the need to check about the pregnancy prevention programme with women of childbearing age and when a referral would be required. Reference materials and leaflets were available to give to people. They also identified other higher-risk medicines, such as warfarin and methotrexate. They would confirm people's current dosage and make sure they had a recent blood test. However, a record wasn't kept about these interventions which could make it harder to respond to future queries.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide the services it offers.

Inspector's evidence

The pharmacy had two calibrated conical measures to help measure liquid medicines. Both were clean. There were two fridges available, one of which was installed in March 2023 to help store cold chain items better. Electrical equipment looked to be in good working order but there was no sign of it being tested. A computer that was used to access people's clinical records was safely stored in the dispensary. Resources such as the BNF were accessed online.

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.