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: 09/05/2024

Pharmacy context

This pharmacy is located within a parade of shops in South East London. The pharmacy mainly dispenses NHS prescriptions. And it provides the Pharmacy First 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 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 adequately manages the risks associated with its services. And it largely keeps the records it needs to by law, so it can show that supplies are made safely and legally. Team members generally respond appropriately when mistakes happen during the dispensing process. People who use the pharmacy can provide feedback. And team members are provided with some training about safeguarding to help ensure that incidents are dealt with appropriately.

Inspector's evidence

Standard operating procedures (SOPs) were available at the pharmacy. They had been prepared in 2016 and last reviewed in 2018. This may mean that they were not up to date or relevant for the services provided at the pharmacy. SOPs for discontinued services were found still in the folder. The superintendent pharmacist (SI) said that he would review the SOPs. All current members of the team had signed the relevant procedures to confirm that they had read and understood them.

Near misses, where a dispensing mistake was identified before the medicine was handed to a person, were seen to be documented routinely. The trainee dispenser said that the SI discussed near misses with them. They described some changes that had been made because of reviewing the record, for example, separating the various strengths of some medicines. Dispensing mistakes which had reached a person, known as dispensing errors, were seen to be documented, but the records were missing the person and prescriber details. This may make it harder to respond to any queries that may arise following the errors. Learning points were relatively vague, for example, some entries stated “more checking”. The SI was not reporting mistakes online, as per NHS requirements. They said that they would look into how they would do this. An SOP covering the process to follow when a dispensing mistake was identified was available, but it was not being followed, for example, the procedure referred to a root cause analysis from the National Reporting and Learning website which was no longer available.

The correct responsible pharmacist (RP) sign was displayed. Team members understood their roles and responsibilities. The RP record was kept electronically, and samples checked were in order. The pharmacy had current indemnity insurance cover. The pharmacy did not provide many emergency supplies. Samples of the private prescription records were generally in order, but some entries were missing the correct prescriber details. Controlled drug (CD) registers were maintained in accordance with requirements. A random stock check of several CDs agreed with the recorded balance.

People were able to provide feedback online or verbally. The SI said that they encouraged feedback from both customers and team members, as it helped the pharmacy team improve their service. The pharmacy had received several positive reviews online.

All team members had read the SOP about data protection. They knew the importance of protecting confidentiality, and described ways they did this, for example, confirming the person’s details before handing out dispensed medicines. Confidential waste was shredded at the pharmacy. Computers were password protected and smartcards were used to access the pharmacy’s electronic records.

Team members had completed some face-to-face training on safeguarding children and vulnerable

adults, but this was some time ago in 2019. An SOP for safeguarding vulnerable people was in place and signed by pharmacy team members. The trainee dispenser described the procedure to follow if they identified a safeguarding concern and understood who the local safeguarding team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just enough staff to manage its workload. Team members are enrolled onto relevant accredited training and provided with time to complete this. And they feel comfortable about raising concerns.

Inspector's evidence

During the inspection there was the SI, a regular locum pharmacist, and a trainee dispenser. The pharmacy also employed a trainee medicine counter assistant (MCA). Team members felt that staffing levels were sufficient for the services provided at the pharmacy. They were observed to be working collaboratively with each other and with people visiting the pharmacy. The SI did the bulk of the dispensing and said that they took a short mental break before checking their work.

Both the trainee dispenser and trainee MCA were enrolled onto relevant courses. The trainee dispenser said they were provided with training time every week. Training records for any ongoing training, aside from the course modules, were not maintained. They mainly worked on the medicines counter and completed other tasks such as expiry date checks, cleaning, and dealing with queries. They were seen to have good rapport with customers. The trainee dispenser was able to explain what tasks they could and could not do in the absence of the RP and said they would refer to the pharmacist if they were unsure of which over-the-counter medicine to supply.

There were no formal appraisals in place, but team members said that they received regular feedback while working. They felt comfortable raising concerns or providing feedback to the SI. Targets were not set for the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the services offered and they are kept secure. There is a room where people can have private conversations with a team member. But the pharmacy could do more to ensure that it keeps all areas tidy and free from potential tripping hazards.

Inspector's evidence

The pharmacy premises were relatively small, cluttered and workbenches were disorganised. The SI said that they were looking to arrange a refit of the dispensary, to create more storage and workspace. Some medicines were stored on the floor in carrier bags and there were also some boxes containing medicines from the delivery on the floor, which presented tripping hazards for the team. There was a swing door restricting access to the dispensary and Pharmacy-only medicines were stored behind the medicines counter. The temperature and lighting were adequately controlled. The cleaning was shared by the team and was done as and when possible.

There was a stock room behind the dispensary which was dark and cluttered. There were boxes and waste bags on the floor, which blocked the back door. There was damage to the flooring, which was not highlighted, and this also posed a trip hazard to the team. The SI explained they were clearing the space in preparation for the partial refit and would ensure that this was clearly signposted. Staff facilities included a WC, with a wash basin. There was a separate sink in the dispensary for medicines preparation with hot and cold running water. There was a hatch between the dispensary and the retail area allowing the pharmacist to oversee the sale of medicines. The retail space was generally tidy and organised and there were chairs available for people waiting.

The consultation room was small and cluttered so there was not enough room for people to use it for a private conversation. The SI explained they were in the process of clearing this out and the pharmacy was not currently providing any services that required its use. The consultation room was locked when not in use. Following the inspection, the SI sent photographs to confirm that the consultation room and dispensary had been cleaned and organised, and that refit work had started. The SI confirmed by email that the refit work would include both the dispensary and storage room.

Principle 4 - Services ✔ Standards met

Summary findings

People can access the pharmacy's services. The pharmacy generally provides its services in a safe way. It orders its medicines from reputable sources and largely manages them properly. But it does not routinely highlight prescriptions for higher-risk medicines, so it may be missing out on opportunities to provide additional counselling. And it does not always maintain clear audit trails for its multi-compartment compliance pack service. This may mean it cannot keep track of when people's packs are due.

Inspector's evidence

Access into the pharmacy was step-free and there was sufficient space in the retail area for people with restricted mobility. Some services were promoted on the window.

The pharmacy had recently started the Pharmacy First service. The SI said that they were not actively promoting the service as they wanted to complete additional training. The SI used the quick reference tool from the National Pharmacy Association when making supplies. Patient Group Directions were not available to view during the inspection, but SI said that they had completed the relevant training. The SI described signposting people to their GP if they were not eligible for supplies under the Pharmacy First service.

There was limited space to dispense on and workbenches were cluttered. Baskets were used throughout the dispensing process to separate prescriptions and prevent transfer of medicines between people. Prescriptions were attached to bags of medicines awaiting collection, and this allowed for an additional check with the person. Dispensing audit trails were not always maintained to help identify who was involved in dispensing and checking a prescription.

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 if a person in the at-risk group was on the pregnancy prevention programme (PPP), and said they drew the person's attention to the warning labels on the medicine packs. Reference materials and leaflets were available to give to people. The SI did not know if anyone in the at-risk group was obtaining valproate from the pharmacy. A prescription for a person in the at-risk group was found on the shelf but the SI did not know if the person was on the PPP. The SI said that they would make the appropriate checks when dispensing this medicine in the future. The SI said that they also identified prescriptions for other high-risk medicines, such as methotrexate. They would confirm people's current dosage and make sure they had a recent blood test. But, prescriptions were not routinely highlighted and a record wasn't kept about these interventions.

The SI was involved in handing out most prescriptions and said they provided additional counselling advice. They stated that they preferred to explain to people what the medicines was for, explain how to take the medicine and highlight to the person if the medicine packaging was different. This allowed for an additional check of the dispensed medicines.

Multi-compartment compliance packs were provided to a few people requiring this support to take their medicines. The SI assembled and checked the trays, usually during closing hours. Several unsealed

trays were found on the shelves. The SI said they had been assembled the day before and required a check. They said they would in future avoid leaving the trays unsealed for prolonged periods of time. People were encouraged to contact the pharmacy once they were on their last pack. This meant that the pharmacy team relied on people to remind them to reorder the repeat prescriptions. The trainee dispenser said that they kept a log of when prescriptions were due 'in their head', which may mean that other members of the team did not know when prescriptions were due. Prepared packs observed were labelled with product descriptions and patient information leaflets were seen to be supplied. The trainee dispenser said that they would create a paper log for team members to refer to, to help keep track of prescriptions for this service.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. Medicines were not always stored in an organised manner on the shelves which may increase the likelihood of picking errors. The pharmacy team checked the expiry dates of medicines at regular intervals and kept records of medicines with short-expiry dates. The records did not indicate when the checks had been made which may make it difficult to keep track of these checks. Several expired medicines were found on the shelves in a random check in the dispensary. Medicines removed from their original packaging were not always labelled with their batch number and expiry date. The fridge temperature was monitored daily. Records indicated that the temperatures were maintained within the recommended range. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier. Drug alerts and recalls were received via an online platform, but several had not been actioned. The SI said that they would action them.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

The pharmacy had two fridges in the dispensary for storing cold chain items. There were two calibrated conical measures to measure liquids. One was clean and the other had some medicine residue in it. There were also tablet and capsule counters available and these were all clean. There was a shredder to dispose of confidential waste. The computer used to access people’s medical records was not visible from the public areas of the pharmacy. Team members were able to access up-to-date reference sources 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.