General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Overdrake Ltd, 40 Neath Road, Hafod, SWANSEA, West Glamorgan, SA1 2ES

Pharmacy reference: 1043869

Type of pharmacy: Community

Date of inspection: 11/07/2019

Pharmacy context

This is a neighbourhood pharmacy in a residential area of Swansea. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It provides dispensing services to a large number of local care home residents. It offers a wide range of services including emergency hormonal contraception, smoking cessation, treatment for minor ailments and a seasonal flu vaccination service by appointment for NHS and private patients. Substance misuse services are also available.

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	1.8	Good practice	Safeguarding is an integral part of the culture within the pharmacy
2. Staff	Standards met	2.5	Good practice	Staff openly raise concerns and provide feedback to improve services
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 has written procedures to help make sure the team works safely. The pharmacy's team members are good at recognising and reporting concerns about vulnerable people to help keep them safe. The pharmacy keeps the records it needs to by law. It asks people to give their views about the services it provides. And it keeps people's private information safe. But its team members do not always record or review their mistakes. So they may miss some opportunities to learn from these.

Inspector's evidence

A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. The pharmacy had some systems in place to identify and manage risk, including the recording of dispensing errors. The last record of a dispensing error had been made some years previously and the superintendent pharmacist said that he could not remember the last time an error had been made. There were no records of near misses. The pharmacist said that he tended to discuss near misses with staff at the time of each occurrence rather than analyse all patient safety incidents on a regular basis to identify patterns and trends.
Some action had been taken to reduce risk: ramipril capsules and tablets had been separated on dispensary shelves to reduce the incidence of picking errors. Staff were aware of the risks of picking errors with 'Look-Alike, Sound-Alike' drugs, such as atenolol, amlodipine, allopurinol and amitriptyline and demonstrated that these were not stored closely together on dispensary shelves. Gabapentin and pregabalin had also been separated to help avoid picking errors.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed on the consultation room door showed that this was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet, although this was not displayed in the retail area.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and properly maintained, including responsible pharmacist (RP), private prescription, specials procurement and controlled drug (CD) records. CD running balances were checked at the time of dispensing, although some items that were not frequently dispensed had not been subject to a balance check for a year or more.

All staff had signed the pharmacy's confidentiality SOP. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. Individual staff members had unique passwords to access the care home dispensing software.

The pharmacist had undertaken formal safeguarding training and had access to guidance and local contact details which he had saved onto the pharmacy's computer desktop. Staff had received in-house training and were able to identify different types of safeguarding concerns. Some of the staff were trained Dementia Friends and all had some experience and knowledge of dealing with vulnerable adults who had memory loss. They said that they had recently contacted a GP with concerns about a regular patient who was becoming very confused and kept attending the pharmacy asking to purchase the same product. The GP had assessed the patient and had arranged for nursing home care.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. They are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The superintendent pharmacist worked at the pharmacy on four days each week. His absences were covered by a regular locum pharmacist. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. Staff members had the necessary training and qualifications for their roles. Two dispensing assistants were training toward an NVQ level 3 qualification.

There were no specific targets or incentives set for the services provided. Staff worked well together and had an obvious rapport with customers since they served a small and close-knit community. They said that they were happy to make suggestions within the team and gave several examples of recent changes that had been made as a result. One example was a file organised in date order that had been created for post-dated prescriptions. They said that this helped prevent these prescriptions from being supplied before their valid date. Staff said that they felt comfortable raising concerns with the superintendent pharmacist, other pharmacists working within the company and the pharmacy owner, who was also a pharmacist. A whistleblowing policy that included a confidential helpline for reporting concerns outside the organisation was available in the dispensary for reference.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients and referred to the pharmacist on several occasions for further advice on how to deal with a transaction. Staff had access to informal training materials such as bulletins from the Local Health Board, articles in trade magazines and information about new products from manufacturers. They said that much of their learning was via informal discussions with the pharmacist. There was no formal appraisal system in place but all staff could informally discuss performance and development issues with the superintendent pharmacist whenever the need arose. However, there was a risk that the lack of a structured training and development programme might restrict the ability of individuals to keep up to date with current pharmacy practice and meant that opportunities to identify training needs might be missed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and secure. It has enough space to allow safe working and its layout protects people’s privacy.

Inspector's evidence

The pharmacy was clean, tidy and well-organised. The dispensary was small but there was enough space to allow safe working. The sinks had hot and cold running water and soap and cleaning materials were available.
A consultation room was available for private consultations and counselling and its availability was clearly advertised.
The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that are easy for people to access. If it can't provide a service it directs people to somewhere that can help. The pharmacy's working practices are generally safe and effective. And it generally manages medicines well. But it doesn't always keep prescription forms with dispensed medicines. This means that the pharmacy's team members may not always have all the information they need when handing out the medicines.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was a step up to the pharmacy entrance, but staff said that they would help patients in wheelchairs into the pharmacy if necessary. There was wheelchair access into the consultation room. A signposting file provided by the local Health Board was available and staff said that they would signpost patients requesting services they could not provide to nearby pharmacies or other providers such as the local surgery, which offered a sharps disposal service. Some health promotional material was on display in the retail area.

Dispensing staff used a colour-coded basket system to ensure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Prescriptions were not always retained for dispensed items awaiting collection. This meant that prescriptions for some Schedule 3 CDs might not be marked with the date of supply at the time the supply was made, as required by legislation. Most prescriptions were scanned and the image remained available for reference. However, this was not the case for all prescriptions. There was no strategy in place to ensure that Schedule 3 or 4 CDs were not supplied to the patient or their representative more than 28 days after the date on the prescription. The pharmacy dispensed medicines against some faxed prescriptions from local surgeries. The pharmacist gave assurances that medicines were not supplied against unsigned faxes and that Schedule 2 or 3 CDs were only ever supplied against the original prescription.

Patients prescribed high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified and there was a risk that opportunities for counselling might be missed. The pharmacist said he asked walk-in patients prescribed warfarin for relevant information about blood tests and dose changes, although there was no evidence of this available. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that one patient who met the criteria for risk had been counselled and provided with patient information. He could not locate the valproate information pack and placed an order for a replacement pack during the inspection. The pharmacy carried out regular high-risk medicines audits commissioned by the local health board. These audits were used to collect data about the prescribing, supply and record-keeping associated with high-risk medicines to flag up areas where risk reduction could be improved within primary care.

The pharmacist said that about 90% of prescriptions were supplied to patients via the pharmacy's delivery service.
Signatures were obtained for prescription deliveries and separate signatures were obtained for CDs. If a patient or their representative was not at home to receive a delivery, the delivery driver usually put a notification card though the door and brought the prescription back to the pharmacy. However, records showed that prescriptions were occasionally posted through letterboxes at the patient's request, which

increased the risk of errors. The pharmacist said that this was always at his discretion after risks had been assessed and was a last resort rather than a routine occurrence.

Disposable MDS trays were used to supply medicines to a number of patients. Trays were labelled with descriptions to enable identification of individual medicines. Staff said that patient information leaflets were routinely supplied. A list of MDS patients was available in the dispensary for reference. Each patient had a section in a dedicated file that included their personal and medication details, details of any messages or queries and any relevant documentation, such as discharge summaries. Progress charts showed who had dispensed and checked each MDS tray, with dates.

Medicines were obtained from licensed wholesalers and stored appropriately including those requiring cold storage.
CDs were stored appropriately in a large, tidy and well-organised CD cabinet and obsolete CDs were segregated from usable stock.

There was some evidence to show that regular expiry date checks were carried out, but the frequency and scope of these checks were not documented. This created a risk that out-of-date medicines might be supplied, and one pot of date-expired tablets was found in the MDS assembly area. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. An unsealed sharps bin containing used sharps was situated in the unlocked consultation room, which could be accessed from the retail area. This was moved into the dispensary as soon as it was pointed out. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist was able to describe how he had recently dealt with a recall for Neupro patches by quarantining affected stock so that it could be returned to the relevant supplier. The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive but the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements. The superintendent pharmacist said that he was currently in discussions with the company's accounts manager regarding the installation of the software and planned to be compliant very soon.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services. The pharmacy's team members use equipment and facilities in a way that protects people's privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Separate measures were used for methadone. These were generally in good condition, but one had a broken base. Triangles were used to count tablets and a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources.
All equipment was clean and in good working order but there was no evidence to show it had recently been tested. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the computer was password-protected and the consultation room was used for private consultations and counselling. Dispensed prescriptions could be seen from the retail area but no confidential information was visible.

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.