General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Wansford Health, Old Hill Farm, Yarwell Road, Wansford, PETERBOROUGH, Cambridgeshire, PE8 6PL

Pharmacy reference: 1099284

Type of pharmacy: Community

Date of inspection: 06/02/2024

Pharmacy context

This community pharmacy is adjacent to a GP practice under the same ownership, in a village close to Peterborough. Its main activity is dispensing NHS prescriptions, the vast majority of which are issued by the adjacent GP practice. And it delivers some of these prescriptions to people at home. It participates in the NHS-funded Community Pharmacist Consultation Service (CPCS), New Medicine service, hypertension case-finding service, and it offers seasonal 'flu vaccinations and Covid-19 vaccinations. It also runs a sleep apnoea detection service and weight management service on a private basis.

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	1.1	Good practice	The pharmacy proactively assesses the impact that new services might have on existing services so it can manage the introduction of these safely.
		1.2	Good practice	The pharmacy regularly reviews its mistakes and shares learnings from these to make its services safer.
2. Staff	Standards met	2.4	Good practice	The pharmacy has a strong culture of openness, honesty and learning. Its team members actively share and learn from mistakes to help make the pharmacy's services safer.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Good practice	4.2	Good practice	The pharmacy can demonstrate how its services, including its novel sleep apnoea clinic, have had a positive impact on people's health and wellbeing.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy considers and manages the risks associated with its services well. It assesses the impact that new services might have on existing services so it can manage the introduction of these safely. It has up-to-date procedures which tell staff how to work safely. And the pharmacy team uses mistakes as opportunities to learn and improve in an open way. The pharmacy largely makes the records it needs to by law. And its team members protect people's personal information.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) for staff to support safe ways of working. These were reviewed regularly to ensure they reflected current services and best practice. And there was a process to track that members of the team had read the procedures relevant to their roles and responsibilities. The superintendent pharmacist (SI) was in the process of producing SOPs in advance of launching the new Pharmacy First service. He had delayed starting the service so the impact on other activities could be properly assessed and managed safely.

Staff were seen carrying out dispensing activities in an organised way. The accuracy checking technician (ACT) had a clear understanding of which prescriptions they could check and how they would identify if a clinical check of a prescription had been done by a pharmacist. There was an audit trail kept showing who had been involved in each stage of dispensing and checking prescriptions. The pharmacy's team members were aware of when they needed to refer queries to the responsible pharmacist (RP) and were seen doing so during the inspection. When asked, team members explained what they could and couldn't do if there was no RP at the pharmacy. The pharmacy did not sell codeine linctus and the trainee medicine counter assistant (MCA) sought advice from the RP before selling any medicines.

The pharmacy kept records about mistakes made and corrected during the dispensing process (near misses). The pharmacy also had a process to record any dispensing mistakes where the medicine reached a patient (errors). These events were reviewed thoroughly to identify how they had happened and to find ways of reducing the chances of them happening again. They were discussed within the pharmacy at the time and during monthly meetings. And errors were also shared as significant events with the GP practice to share learnings. Changes introduced as part of safety reviews had included attaching 'similar name' stickers to prescription bags to alert staff when handing out prescriptions to check people's names carefully. And displaying a list of medicines with similar names or appearances in the dispensary to highlight these to dispensers.

The pharmacy had a complaints procedure and forms to record formal complaints were available. In practice, complaints were generally referred to the SI who was at the pharmacy on most days. The pharmacy had professional indemnity and public liability insurance in place.

A poster showing details about the RP on duty was displayed where people visiting the pharmacy could see it. And it was correct. The record about the RP was available and was complete. Private prescriptions were recorded electronically. Some records about these did not include the right information about the prescriber; the SI said he would address this with the team. Records viewed about controlled drugs (CDs) were up to date. Running balances were recorded and checked regularly.

The recorded stock of two items chosen at random agreed with physical stock. CDs returned by people were destroyed appropriately. And obsolete CDs were separated from dispensing stock to prevent mistakes happening.

When asked, team members understood the need to keep people's information private and there was information displayed for people about how the pharmacy managed their personal information. There were written procedures to protect people's information, and these had been read by the staff. Training on protecting information was mandatory and was refreshed regularly. The pharmacy was registered with the Information Commissioner's Office. Computer screens containing patient information and prescriptions waiting to be collected could not be seen by the public. Team members used their own NHS smartcards when accessing electronic prescriptions and summary care records and they did not share passwords. Confidential waste was separated from normal waste and was disposed of securely.

To ensure vulnerable people were protected, pharmacists and team members had completed levels of safeguarding training relevant to their roles. The SI described how safeguarding concerns would be handled and there was a safeguarding lead in the adjacent surgery. People could request a chaperone when using the consultation room and information about this was displayed in the shop area.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff with the right skills to manage its workload safely. The pharmacy's team members work closely together and communicate well with each other, sharing information appropriately to make the pharmacy's services safer. And they are suitably trained or are undertaking the right training for the roles they undertake. Newer members of the team are given appropriate support and supervision and team members have the opportunity to continue to learn and develop. Pharmacy professionals can exercise their professional judgement and have the necessary support in place to help them undertake their roles safely.

Inspector's evidence

Both the regular pharmacist and SI were present during the inspection, and both worked most days at the pharmacy, meaning there was ample cover to deliver the pharmacy's services across the week. The rest of the pharmacy team comprised an accuracy checking technician, a pharmacy technician, two dispensing assistants, and two medicine counter assistants (MCAs). There was also a delivery driver who was on leave and a courier had been arranged to provide cover in the interim.

Most of the team members had worked in the pharmacy for some time and were seen discussing queries with each other and supporting each other well. They appeared able to cope with the current workload and people visiting the pharmacy during the inspection were served with reasonable promptness. And trainee members of staff underwent an induction period prior to being enrolled on the appropriate training for the roles they undertook. When asked, a trainee MCA explained how they would refer to the pharmacist when selling medicines over the counter.

There was very good communication amongst the team members and close working with the surgery staff. The SI could discuss operational matters with the pharmacy owners and was fully involved in making decisions about the pharmacy's operations. The team used communications apps to share important information and updates. There were also message boards in use in the dispensary giving updates about stock shortages and alerting staff to certain pack sizes in use. And there were monthly team meetings to discuss learnings from incidents and other updates.

Team members were given set-aside time at work to complete mandatory training including training about managing people's information, and health and safety. They had annual appraisals to discuss their progress and performance. And they had opportunities to continue to develop their skills and knowledge; dispensers had been supported to train to become pharmacy technicians. Those team members asked said they would feel comfortable discussing any concerns with the regular pharmacist or the SI. And there was guidance available to the team about the pharmacy's whistleblowing procedure.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for providing pharmacy services safely and they are maintained appropriately. People wishing to have a private conversation with members of the pharmacy team can do so in the pharmacy's consultation room.

Inspector's evidence

There was a ramped entrance available to people into the pharmacy to assist those with prams or wheelchairs. The small waiting area had some seating and was clear of clutter or trip hazards. Access to the dispensary and consultation room was controlled. Members of staff had good visibility of the medicine counter and pharmacy-only medicines were stored out of reach of the public. The pharmacy could be secured against unauthorised access. People's information on dispensed items waiting to be collected could not be seen by members of the public.

The dispensary had enough room for the workload to be undertaken safely and the pharmacy premises were clean and well-maintained. A dispensing robot was in use and there were maintenance and emergency call-out arrangements in place to support its use. There were also contingency arrangements in the event of the robot malfunctioning to keep the surgery informed of potential delays to service. The private consultation facilities were a reasonable standard and provided a place for people to have private conversations and access pharmacy services in a suitable environment.

The room temperature was appropriate for storing medicines and could be controlled. Lighting was suitable for safe dispensing. The pharmacy team members had access to appropriate hygiene facilities and rest areas. The sink in the dispensary used for reconstituting medicines was clean.

Principle 4 - Services ✔ Good practice

Summary findings

The pharmacy manages its services effectively. It has close partnership working with other healthcare providers. And it can demonstrate how its services have had a positive impact on people's health and wellbeing. It stores its medicines appropriately. And it has good processes in place to make sure the medicines it supplies are safe for people to use.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. There was some health information literature about self-care displayed in the retail area. There was onsite parking and some seating for people waiting for pharmacy services. An induction hearing loop was available. The pharmacy delivered medicines to some people who could not collect medicines from the pharmacy themselves. There was an audit trail kept for deliveries and a process to make sure items were not left unattended at a person's home.

Baskets were used to keep prescriptions for different people separate. There was an audit trail on prescriptions to show who had completed each step of the process from clinical screening to accuracy checking. And designated parts of the dispensary were reserved for certain tasks such as accuracy checking to reduce risks. The team could explain where to place dispensing labels on packs of valproate-containing medicines so as not to obscure important information. And they knew about updated guidance including original pack dispensing and advice to give to people about pregnancy prevention. The pharmacy didn't currently supply valproate-containing medicines to anyone in the at-risk group. The pharmacy had processes to identify prescriptions for other higher-risk medicines so that checks could be made with people to ensure they were being monitored appropriately. These included annotating prescriptions with 'monitoring' and checking people's medical records for evidence of blood tests when conducting clinical checks.

The pharmacy had good mechanisms to be able to refer people to the surgery quickly if needed and were trialling the use of GPConnect to help with this. They gave examples of how this had helped make sure people got the care they needed without delay, particularly in relation to CPCS referrals. There were also examples given about blood-pressure checks which had resulted in prompt medical intervention.

A novel service had been introduced by the pharmacy over the past year which helped to identify people who may suffer from sleep apnoea. At the time of this inspection, this pharmacy was the only one in the country to offer this service. The regular pharmacist was the lead for this service, and they had seen around 50 people so far. Following a structured consultation, the pharmacist was able to offer next steps including a monitoring device which could track the person's breathing patterns overnight and produce a meaningful report. The information elicited from the monitoring device had meant onward referral to a sleep clinic was based on actual clinical data and had reduced the referral time greatly in for some people.

Medicines were obtained from licensed suppliers. The pharmacy worked closely with the surgery to minimise the impact of medicine stock shortages, seeking alternatives where this was possible. Most

medicines were stored in and dispensed from the dispensing robot, including split packs. There was a process to date-check all medicines regularly and, when shelves were spot-checked, no date-expired medicines were found. Waste medicines were kept in designated bins and disposed of safely.

Medicines that required refrigerated storage were kept in the pharmacy's fridges. Maximum and minimum fridge temperatures were monitored and recorded for the fridges and had remained within the required range. There was enough storage capacity in the fridges and no evidence of ice build-up. The pharmacy received safety alerts and recalls about medicines and acted on these appropriately.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. It keeps sensitive information on out of view of the public to protect people's confidentiality. And it has systems in place to make sure its equipment operates correctly.

Inspector's evidence

The pharmacy had a service and contract agreement in place for the dispensing robot and contingency arrangements in the event the robot stopped working. Other electrical equipment was safety tested. The electronic patient medication record system was only accessible to pharmacy staff and computer screens could not be viewed by the public. The pharmacy had cordless phones, and staff could move to private areas to hold phone conversations out of earshot of the public. Staff had a range of reference sources to use, including online resources, so advice provided to people was based on up-to-date information. The equipment used for measuring liquids was of an appropriate standard and was clean. There were denaturing kits available to dispose of CDs safely.

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.