General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ryburn Pharmacy, Hirstwood, Ripponden, HALIFAX, West Yorkshire, HX6 4BN

Pharmacy reference: 1101364

Type of pharmacy: Community

Date of inspection: 30/01/2024

Pharmacy context

This pharmacy is located in a health centre in the village of Ripponden, Halifax. The pharmacy dispenses NHS prescriptions, and it supplies medicines in multi-compartment compliance packs to people who need help managing their medicines. It also offers the New Medicine Service (NMS) and a medicine delivery service.

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 effectively manages risks to make sure its services are safe. Its team members record their mistakes so that they can learn from them, and they make changes to help reduce the chance of the same type of mistakes from happening again. It keeps the records it needs to keep by law, and these are largely accurate and up to date. And it protects people's personal information appropriately. Members of the team understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

Standard operating procedures (SOPs) were available and had been read by team members with the exception of the locum dispenser. The superintendent pharmacist (SI) explained that the processes and systems that were in place had been discussed with the locum dispenser when he had first started working at the pharmacy. And they had asked him to complete some basic activities to assess his competency. SOPs were in the process of being reviewed and were due to be moved to electronic versions.

Dispensing mistakes which were identified before a medicine was supplied to people (near misses) were highlighted to the team member involved in the dispensing process and then recorded in a near miss log. Near misses were seen to be recorded consistently. The SI carried out a review of all near misses every three months which included a breakdown of the number of different types of errors. The top three occurring patterns or trends were identified, and steps had been taken to avoid reoccurrence. A copy of the review was printed and displayed prominently in the dispensary where it could be regularly seen by all the team. Following the last review team members were asked to take more time when dispensing. As part of the review medicines which looked or sounded-alike were also discussed. The SI explained there had not been any mistakes where the wrong medicine was supplied to a person (dispensing errors) in the last few years. He explained that any dispensing errors would be reported on the National Reporting and Learning System (NRLS) and reviewed so that members of the team could learn from them.

A correct Responsible Pharmacist (RP) notice was displayed. When questioned, team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure and complaints were dealt with by the SI or other pharmacists. Team members explained that they learned to improve the way they communicate with carers and family members of the person they have supplied medicines to due to a result of miscommunication.

Private prescription records, emergency supply records, records for unlicensed medicines supplied, RP records and controlled drug (CD) registers were well maintained. Although, there was some overwriting seen in some of the CD registers where a mistake had been made and not correctly annotated. Running balances for CDs were recorded. A random balance was checked and found to be correct. CDs that people had returned to the pharmacy were recorded in a register and appropriately destroyed.

Assembled prescriptions, which were ready to collect, were stored in the dispensary and not visible to people using the pharmacy. The pharmacy had an information governance policy available, and its team members had completed training about it. The pharmacy stored confidential information securely and

separated confidential waste which was then shredded. Pharmacists had access to summary care records (SCR) and obtained verbal consent from people before accessing it.

The SI and technicians had all completed level two safeguarding training. All other team members, including the delivery drivers, had completed level one safeguarding training. When questioned, team members were able to explain the signs to look out for which may indicate a safeguarding concern. And they would refer any concerns to the RP.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the pharmacy's workload and they receive appropriate training to carry out their roles safely. The pharmacy helps its team members to keep their knowledge and skills up to date and encourages team members to upskill and progress in their roles. Team members can provide feedback and concerns relating to the pharmacy's services.

Inspector's evidence

The pharmacy team comprised of three pharmacists, including the SI, five pharmacy technicians who worked as accuracy checkers (ACT) two of who were trainees, two trained dispensers, a trained medicines counter assistant (MCA) and two delivery drivers. Usually there were two pharmacists working alongside each other. However, as one of the pharmacists was on leave the pharmacy were using a locum dispenser. The SI felt that there were enough staff to manage the workload but was looking to recruit an additional dispenser. The team were observed working effectively together and were up to date with the workload.

Team members asked appropriate questions and counselled people before recommending over-the-counter medicines. They were aware of the maximum quantities of medicines that could be sold over the counter and would refer to the pharmacist if unsure.

Staff performance was managed informally by the SI. The SI explained that the team was small and worked closely together and any issues were addressed as they occurred. In the past the SI completed appraisals but hadn't found them useful. The SI described that the pharmacy's ethos was to get people to train, and this explained why most members of the team had trained to become accuracy checkers. To keep up-to-date, team members were provided with leaflets and training material as it was received. The pharmacy technicians managed their own CPD and training. Team members completing formal training were provided with protected learning time at work.

Team meetings were held on an ad-hoc basis to discuss workload, changes to processes or any issues anyone wanted to raise. The team were briefed when new services were launched. The SI let the team know when new safety reviews of near misses were due. Team members felt able to raise concerns, provide feedback and give suggestions. The ACT described that she had suggested prescriptions be placed in a particular way in baskets to make it easier when people were looking for someone's medicines which had been implemented. There were no targets or incentives in place for any of the services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and they are clean and secure. A consultation room is available so people using the pharmacy can have a private conversation with its team members.

Inspector's evidence

The pharmacy was clean, tidy and organised. The dispensary had limited workspace, but this was allocated for certain tasks to help manage the workload safely. Shelves had been created to store baskets containing dispensed prescriptions waiting to be checked as well as part-dispensed prescriptions to ensure there was sufficient workbench space. Additional shelving had been added to store assembled prescriptions waiting to be collected.

A clean sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by a designated cleaner and team members. The room temperature and lighting were appropriate, and the premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for people to have a private conversation.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible. And it generally manages and provides them safely. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they are safe to supply to people.

Inspector's evidence

The pharmacy was easily accessible from the street. There was level access from the car park. The shop floor was clear of any trip hazards and the retail area was easily accessible. Team members assisted people who needed help entering the pharmacy and the pharmacy provided a medicine delivery service. When it was necessary, the pharmacy team used the internet to find out the details of local services so that they could signpost people who needed services that the pharmacy did not provide. Some of the team members were multilingual to help meet the needs of people in the local area.

The SI felt that the blood pressure (BP) check service, and New Medicine service (NMS) had a positive impact on the local population. The pharmacy received positive feedback from people who had received an NMS, particularly if they were experiencing problems with their new medicine and in such cases, a referral was made. Since the pharmacy had started checking people's BP, they had noticed that the local GPs had also increased the number of checks they routinely completed. As part of the service there had been cases where referrals had been made and the person was consequently prescribed medicines for high blood pressure.

The pharmacy received prescriptions electronically. They were processed and labelled by one of the dispensers. The pharmacy had 'labelled by' 'dispensed by' and 'checked by' boxes available on dispensing labels. These were initialled by team members as each process was completed so it was easy to identify who was involved in the dispensing process. Prescriptions were then sorted into colour-coded baskets and dispensed. Baskets were also used to separate prescriptions, preventing transfer of medicines between people. If any interventions or new medicines were flagged during the labelling process, these were given to the pharmacist to check. Accuracy checking was shared between the ACTs and pharmacists. Repeat prescriptions were predominantly checked by one of the ACTs and pharmacists checked all acute prescriptions. ACTs were able to check most medicines. CDs and high-risk medicines were double checked by a pharmacist.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). The team were aware of the labelling requirements and requirement for sodium valproate to be dispensed in its original packaging. The position of where the label had been attached to the pack was checked as part of the final accuracy check. The RP described that there was one person who did not fall in the at-risk group and had their sodium valproate supplied in a compliance pack. This had been assessed by the pharmacist and the person was known to pharmacist for a number of years The pharmacy carried out some checks on medicines that required ongoing monitoring. The team worked closely with the surgery and were aware that the surgery withheld prescriptions if blood tests were overdue. Details about INR readings and checks were carried out for people who had their medicines supplied in compliance packs. Details of any checks carried out were not routinely recorded. This could mean that any information collected is not available for future checks.

Some people's medicines were supplied in multi-compartment compliance packs to help them take their medicines at the right time. And a few people had their medicines supplied in Pivotal packs. Individual records were kept for each person and detailed all their current medicines and any notes regarding changes. All prescriptions were checked against the records and if there were no issues these were passed through to the dispensing queue. Packs were prepared and checked by one of the ACTs. The SI agreed that there were risks involved with self-checking and provided an assurance that another dispenser would prepare future packs. Assembled packs were labelled with product descriptions and mandatory warnings. Patient information leaflets (PILs) were routinely supplied with the packs.

Deliveries were carried out by the delivery drivers who had a set route for each day. Signatures were obtained when CDs were delivered. In the event that someone was not home, medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and were stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of cold chain medicines. Team members were able to describe the actions they took if the temperature was outside of the required range. CDs were kept securely. Expiry dates were checked routinely and the dispensary had been split into sections which were assigned to different team members. Short dated stock was marked in way so that it could be easily identified. An updated date checking matrix was seen. No date expired medicines were found on the shelves. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. Drug recalls were received by email. They were printed, actioned and shared with the team.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it uses its equipment in a way to protect people’s private information.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment was available. Separate measures were used for liquid CD preparations to avoid cross-contamination. Equipment was clean and ready for use. Up-to-date reference sources were available electronically. A blood pressure monitor was available which was used as part of the services provided. This was fairly new, and arrangements were in place to have it calibrated annually. The pharmacy had a medical grade fridge and CD cabinet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy; a cordless phone was available which helped members of the team have a private conversation with people.

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.