General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ryans Pharmacy, 126-128 Bradford Road, Brighouse, West Yorkshire, HD6 4AU

Pharmacy reference: 9012212

Type of pharmacy: Internet / distance selling

Date of inspection: 18/09/2024

Pharmacy context

This pharmacy is situated in Brighouse and recently relocated to a larger premises. It supplies all of its services at a distance. The pharmacy dispenses NHS prescriptions which are delivered to people. It offers some NHS services such as the New Medicine Service (NMS) and the Pharmacy First 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 adequately identifies and manages the risks associated with its services to help provide them safely. The pharmacy largely keeps the records it needs to by law and has procedures in place to learn from mistakes. And it protects people's personal information appropriately. People can provide feedback about the pharmacy's services.

Inspector's evidence

Standard operating procedures (SOPs) were recently reviewed and made available to the pharmacy team members by the pharmacy manager. They had read and signed SOPs relevant to their roles to confirm their understanding. SOPs were reviewed annually by the pharmacy manager.

Risk assessments were not available at the pharmacy during the inspection but were subsequently provided. There was a separate risk assessment for the pharmacy service, which looked at areas such as staffing, record keeping, equipment, training and the workspace. Other risks were also addressed within the business continuity plan however areas such as prescription security, medication errors, and storage and security of medicines were not included. Which means that some risks may be overlooked.

Dispensing mistakes which were identified before medicines were supplied to people (near misses) were corrected, recorded, and discussed with the team members. Near misses were reviewed each month and discussed at a team meeting. Team members had been briefed to take extra care when dispensing. Mistakes made during the dispensing process that hadn't been identified before being supplied to people (dispensing errors) were reported to the online National Reporting and Learning System (NRLS). The team also held a discussion as to how a similar error could be avoided in the future. As a result of a past error where someone had been supplied with less tablets in a compliance pack, team members had been asked to collect the full quantity of all the medicines needed when picking stock so that it acted as a prompt if there were excess tablets after the packs had been made. Dispensing errors were reviewed along with near misses each month.

The pharmacy had current professional indemnity insurance which covered all the services provided. The pharmacy had a complaints procedure and a complaints section on the website that people could use. Complaints usually came through to the superintendent pharmacist (SI) and were usually resolved in a timely manner. Team members described that feedback was usually relating to deliveries.

The correct RP notice was displayed. RP records, and records of unlicensed medicines supplied were well maintained. Controlled drug (CD) registers were generally well maintained, but a number of headers were missing from most registers seen. This was legally required and could mean that the pharmacy would not be able to reconcile the page to the correct register if it became loose. The pharmacy was due to move to electronic CD registers. Running balances were recorded and checked against physical stock. A random balance was checked and found to be correct. A register was available to record CDs that people had returned. The pharmacy had not dispensed any private prescriptions.

The pharmacy had an information governance policy which had been read and understood by all team members. The pharmacy stored confidential information securely and separated confidential waste

which was then shredded. The pharmacists had access to national care records (NCR) and obtained verbal consent from people before accessing it.

Team members, including delivery drivers, had all completed safeguarding training. If the team had concerns, they would refer to the RP and were aware of the next steps to follow.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained staff to provide its services effectively. Team members are trained, or are in the process of completing the appropriate training, for their roles and the tasks they complete. The pharmacy helps its team members to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy team comprised of two pharmacists, four trained dispensers, three trainee dispensers, an apprentice and a team member who had recently been employed by the pharmacy. They were due to be enrolled on the dispenser course. The pharmacy also had four delivery drivers. The SI felt that there were enough staff. He explained that there was a good workflow which helped manage the workload effectively. The team were split between two dispensaries and they although were allocated to one area, they were trained to be able to complete tasks in both in the event that cover was needed.

The performance of the pharmacy team members was managed by the directors of the company. Team members were provided with feedback on an ongoing basis and had annual appraisals. Team members felt able to raise concerns or speak to the directors about suggestions and feedback.

The team used training packages from a third-party pharmacy support group to help team members keep up to date. The pharmacy was sent a booklet with training material which the team looked through and discussed together at monthly meetings. In addition to this, the pharmacy manager also provided links for any online training which needed to be completed. Team members were provided with time to complete their ongoing training as well as their formal training courses. Team members who were completing their formal training courses felt well supported by the pharmacists and colleagues.

The team held monthly meetings on a Wednesday when most team members were working. The meeting was usually led by one of the dispensers. The team had started keeping meeting notes electronically so that these could be emailed to all team members. Meetings were used to review any issues, discuss near misses and dispensing errors, training and any changes to services. There were no targets in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are clean and secure. The pharmacy's website gives people clear information about who is providing its services.

Inspector's evidence

The pharmacy was split over two floors and was clean and organised. The main dispensary was on the first floor and was used for dispensing medicines for people residing in care homes. The dispensary on the second floor was used for preparing multi-compartment compliance packs. There was ample workbench space in both dispensaries, which were tidy and clear of clutter. Workbenches were generally allocated for certain tasks to help with an efficient workflow. A room on the first floor was used as an office and for checking medicines for care homes residents. A sink was available on the first floor in a room adjacent to the dispensary. The pharmacy had a stock room on the second floor. Cleaning was done by the team and there was a rota in place. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of healthcare services.

The pharmacy had its own online website (https://ryans-pharmacy.co.uk/). The website gave clear information how people could make a complaint, how people could contact the pharmacy and the GPhC registration information for the pharmacy, SI and its owner. The pharmacy did not provide any services or sell any medicines from its website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely provides its services safely. It obtains its medicines from licensed sources and manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy was a distance selling pharmacy, so medicines were not supplied directly to people using the pharmacy. The pharmacy website listed the services it provided and displayed the pharmacy's opening times. Prescriptions were predominantly received by the pharmacy electronically. People were signposted to other services where appropriate and the team had a folder with information about local services. They also used the internet to find out details of services local to where the person resided. Team members were multilingual and spoke most of the languages spoken locally. The SI explained that the pharmacy phone was diverted to one of the pharmacists out-of-hours and they were able to signpost people to other services or provide advice if needed. Services such as NMS and Pharmacy First were provided via telephone or video call.

Prescriptions were ordered by care homes directly from the GP surgery. A copy of the reorder sheet was sent to the pharmacy. Team members went through individual reorder sheets and highlighted any missing items and information of the missing items was sent back to the care homes. The dispensary was arranged in a way to manage the workflow and a separate room was used to carry out a final check on the dispensed medicines, prescriptions and medication administration charts (MAR). In the event that packs were prepared in advance of receiving prescriptions, the MAR charts were only prepared once the prescription was received. Hospitals usually contacted the pharmacy when someone was admitted into hospital and sent a discharge summary which was checked by the pharmacist.

Acute prescriptions for people residing in care homes were sent to the pharmacy automatically. The pharmacy did not have a cut-off point for same day delivery. MAR charts were provided and sent with the driver. The care home also called and notified the team if there were any acute prescriptions expected or if there were changes to anyone's medication. The pharmacy had three telephone lines to ensure calls were not missed.

Multi-compartment compliance packs for people who lived in their own homes were prepared and managed in a separate dispensary on the first floor of the premises. Each individual patient had their own basket and had a record of all the medicines they were taking. The team used different coloured baskets depending on the week that the packs were due to go out to help organise the workload. Prescriptions were ordered by the pharmacy. The dispensers had an audit sheet which had details of all the prescriptions that had been ordered. Once a prescription was received, the record was marked with a highlighter and once the packs had been prepared a tick was made next to the patient's name. Repeat dispensing batch prescriptions were available for a number of people. Prescription forms were kept with prepared packs and they were not supplied if a prescription had not been received. The RP completed an accuracy check of the packs once they had been assembled.. A third check was carried out by the pharmacist downstairs on the day that the pack was due to be delivered.

Some people's medicines were supplied in the Pivotal compliance packs. These were first dispensed,

and accuracy checked into a disposable compliance pack. They were checked again after it had been transferred to the Pivotal system. Backing sheets were prepared and supplied with all Pivotal packs.

The team were notified when someone was admitted into hospital, and they placed a note on the person's compliance pack.. Discharge information was received on PharmaOutcomes. Assembled packs were labelled with the product descriptions and mandatory warnings. However, the backing sheets were placed loosely within the packs. The dispensers provided assurance that these would be securely attached to the packs. 'Dispensed-by' and 'checked-by' boxes were available on dispensing labels and were routinely signed. Patient information leaflets were not routinely supplied. The team provided an assurance that these would be handed out monthly.

The pharmacy team were aware of the risks associated with the use of valproate containing medicines during pregnancy. The pharmacy supplied some people with sodium valproate in compliance packs. A written risk assessment had not been completed to demonstrate that the risks of not providing valproate in its original pack had been assessed. The SI provided assurance that this would be completed. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring.

The SI was an independent prescriber but did not provide any prescribing services from the pharmacy. Prior to the launch of the NHS Pharmacy First service, the SI had read the associated guidelines and the PGD. As the pharmacy provided the service at a distance, they did not provide the acute otitis media service. Consultations were either carried out over the telephone or via video call. Signed PGDs were in place for the service.

Deliveries were carried out by one of the four delivery drivers. Delivery sheets were made for each driver who marked off and recorded the time when deliveries were made. Signatures were obtained when medicines were delivered to care homes. If people were not available to accept the delivery the medicines were returned to the pharmacy. The pharmacy used a tracked delivery service for medicines that could not be delivered by the drivers.

Medicines were obtained from licensed wholesalers and stored appropriately. These included medicines requiring special storage consideration such as CDs. Fridge temperatures were monitored daily and recorded; these were within the required range for storing temperature-sensitive medicines. There was a considerable amount of ice at the back of the fridge. The SI provided assurance that this would be cleaned and explained that a new fridge had already been ordered. Date checking was done by one of the dispensers every three months. Short-dated stock was marked with red stickers and a record of the short dated medicines was made. The pharmacy was in the process of creating a date-checking matrix. A random sample of stock was checked, and no expired medicines were found. Out-of-date and other waste medicines were separated and collected by licensed waste collectors. Drug recalls were received electronically. The team would check the stock and take the action as required; a printed record was kept in the pharmacy. Nursing homes also called to check if they had been supplied with any of the affected batches.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had calibrated glass measures for water but was using plastic measures for liquid CDs. The pharmacy manager ordered suitable glass measures when this was identified. Tablet counting equipment was available. Equipment was clean and ready for use. A medical fridge was available. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and team members had individual passwords.

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.