General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: AYP Healthcare Ltd, Unit 9, Guardian Business Centre, Faringdon Avenue, Harold Hill, Romford, RM3 8FD

Pharmacy reference: 9010499

Type of pharmacy: Closed

Date of inspection: 10/12/2020

Pharmacy context

This pharmacy supplies its services at a distance, and it is located in a business centre. The pharmacy dispenses NHS prescriptions which are supplied to care homes predominantly in London and Essex. It offers Medicines Use Reviews (MURs), off-site flu vaccinations and a delivery service. This was a targeted inspection following conditions being imposed on the pharmacy's registration. The inspection was undertaken during the Covid-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It keeps the records it needs to keep by law and these are largely kept accurate and up to date. The pharmacy learns from mistakes that happen during the dispensing process to help make its services safer. And people can provide feedback about the pharmacy's services.

Inspector's evidence

Standard operating procedures (SOPs) were available and team members had read and signed SOPs which were relevant to their roles. Team roles were defined within the SOPs. Some SOPs did not relate to the pharmacy and the RP gave an assurance that he would look through the SOPs and remove those which were not relevant.
The team had been routinely ensuring infection control measures were in place and cleaned the pharmacy regularly through the day. Team members who carried out deliveries had been provided with personal protective equipment (PPE). Due to the size of the pharmacy, team members were able to work at a distance from other colleagues. The responsible pharmacist (RP) was also the superintendent pharmacist and explained that the necessary risk assessments to help manage Covid-19 had been completed and this included occupational ones for the staff.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). The RP informed the person who had made the mistake and a record was made in the near miss record book. There were some gaps in the record particularly when the RP had been away. Near misses were reviewed by the RP each month and findings were shared with the team. As a result of past near misses, medicines had been moved on the shelves. The team had also recently rearranged how medicines were stored on the shelves to help prevent any picking mistakes. If team members were repeatedly making the same mistake the RP retrained them or delegated a different task to them. In the event that a dispensing error was reported the pharmacy would collect the medication from the care home, rectify the error and make a note on the person's electronic medication record. Completing a dispensing incident report form was discussed with the RP.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure as part of the SOPs. Care home staff were able to contact the pharmacy over the telephone or via email and the RP would try and resolve any complaints. Team members were not aware of any recent feedback or complaints which had required action. The correct RP notice was displayed. Team members were aware of the tasks that could and could not be carried out in the absence of the RP.

The pharmacy had not dispensed any private prescriptions or made any emergency supplies. Records for unlicensed medicines, controlled drug (CD) registers (electronic) and RP records were well maintained. CD balance checks were frequently carried out. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received.

Team members had signed a confidentiality agreement and an information governance (IG) policy was available. Team members had completed training on data protection. The premises were not accessible to members of the public. Confidential waste was collected and sent to the pharmacy's Preston site for

shredding. Computers were password protected and access to the PMR system was via individual NHS smartcards. Lockable cupboards were available and used to store confidential records.

The RP had completed the level two safeguarding training course. Team members had read through the SOP and would raise any concerns with the RP. Two posters detailing safeguarding procedures were displayed in the pharmacy. Details of local safeguarding contacts were available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They can raise any concerns or make suggestions and they can take professional decisions to ensure people taking medicines are safe. Where relevant, the pharmacy generally enrols staff on a suitable accredited training course for their role. But it does not always do this in a timely manner.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, three trained dispensers, and three dispenser trainees. And there was another team member who had started working at the pharmacy nine months prior to the inspection and had not been enrolled on any training course. Another member of staff who carried out deliveries also occasionally helped in the pharmacy, and on the day of the inspection had been sorting out medicines people had returned to the pharmacy. Following the inspection, the RP confirmed that team members had been enrolled on accredited courses suitable for their roles.

Staff performance was managed by the RP and owner, with annual appraisals completed. The RP also gave team members feedback through the year. The RP would speak to the owner if there were any major issues. The RP also felt able to share feedback and suggestions with the owner and had the autonomy to provide services in a way that he felt suitable. As well as make changes to the day-to-day running of the pharmacy as long as it did not have any financial implication.

Team members were provided with set-aside training time to complete their course modules. The RP was their tutor and would answer any questions they had. There was no formal process in place for ongoing training and the RP verbally briefed the team if there were any changes to guidance or legislation.

Since the latest inspection at the pharmacy's sister branch in Preston, the RP said that he was in contact more often with the branch. The RP was also consulted before new medicines were added for sale at the other branch.

Things were discussed as they arose and information was shared between the RP and owners over the telephone. The team felt able to share concerns and suggestions with the RP, who listened and acted where needed. Team members could also speak directly to the owner if needed. Targets were not set for team members. The RP felt confident about taking professional decisions.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy’s services and are clean, tidy and secure.

Inspector's evidence

The pharmacy was located in a gated business unit and was very spacious and clean. The dispensary was large with ample workspace which was allocated for certain tasks. The work benches used for dispensing and checking were clear and organised. Dispensary shelves were tidy and organised. A sink was available for the preparation of medication. Cleaning was done by the team and team members were able to maintain distance from each other.

The premises were generally kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of healthcare. The room temperature was monitored regularly by the RP. More lights were also due to be fitted and in summer portable fans were brought in to help maintain the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. It obtains its medicines from reputable sources, and manages them appropriately so that they are safe for people to use. Team members take the right action when safety alerts are received, to ensure that people get medicines and medical devices that are safe to use. But they don't routinely record what action they have taken about these alerts. This could make it harder for them to show what they have done in response.

Inspector's evidence

The pharmacy was closed to people physically accessing it. Services provided including the care home service were advertised on the pharmacy's website and on NHS Choices. The pharmacy had an allocated team member who called care homes to inform them of the services provided by the pharmacy. The RP called care homes to which the pharmacy was already delivering medicines to inform them of additional services available such as MURs and flu vaccinations. The RP had NHS clearance to provide these services off-site.

The pharmacy mainly delivered to care homes locally and nearby in Essex and Enfield. Most care homes received acute medicines from local pharmacies. Care home managers had been provided with telephone numbers of the RP and one of the more experienced dispensers.

One of the dispensers visited the care homes to carry out checks and complete audits. Information and training were provided to care home staff on storage and administration if issues were identified as part of the audit. Care homes were usually visited annually but more frequent visits could be planned if needed such as before a CQC inspection. Due to the Covid-19 pandemic training had been stopped although audits were still being carried out.

Prescriptions were either ordered by the pharmacy or the care home. Care homes were asked to fill in reorder sheets to confirm items required before the pharmacy reordered the prescriptions from the GP (reorder forms were supplied with every cycle). For care homes who ordered their own prescriptions a copy of the completed reorder form was also sent to the pharmacy. The pharmacy followed up with the prescriber if prescriptions were not received. In the event that any items were missing the pharmacy either contacted the prescriber directly or notified the care home depending on the reordering arrangement. The pharmacy did not order acute prescriptions. These were sent directly by the prescribers.

The pharmacy either provided people's medicines in multi-compartment compliance packs or in Biodose packs (approximately 60% of patients). Once prescriptions were received, they were processed by one of the dispensers who generated labels and administration (MARR) charts. A separate system was used to label the Biodose packs. Once the dispenser had inputted data into the system the prescriptions were sorted into two trays. Another two dispensers would then pick the stock and inform the RP of any missing items. These were then dispensed by another dispenser. If prepared packs needed to be racked this would be done by a different dispenser. Team members were delegated tasks. Assembled packs were then checked by the pharmacist. Dispensed and checked-by boxes were available and were being used. Each care home had a specific ordering sheet, the RP used this to identify who had picked stock if there was a picking error.

The RP was notified by the care homes if there were any changes to people's medicines. This was recorded on the sheets. Information for new patients was checked on the Summary Care Records and confirmed with the care homes. MARR charts were updated with any allergies listed. Patient information leaflets were supplied monthly. For some care homes people's photographs were printed on their MARR charts to assist care home staff.

The pharmacy used whiteboards to track when care homes were due and worked a week in advance. Weeks were colour-coded and more team members were brought in to help with the workload during busy weeks. The pharmacy was working a few weeks ahead to ensure medicines were ready for the Christmas period.

There were delivery cut-off times which care homes were made aware of for acute medicines. The care home was contacted if prescriptions were received after the cut-off time to check if items were urgent. Electronic prescriptions were sent back to the NHS 'spine' so that carers were able to collect medication from other, local pharmacies (the care home was also emailed the prescription barcode). If prescriptions were received before the cut-off time, they were delivered the same evening; the care home was contacted if stock was not available. Communication between care home staff and the pharmacy team was not always documented. So, this could make it harder for the pharmacy to show what had been communicated if there was a future query.

Care homes contacted the RP before medicines were administered covertly. Care home staff had a one-to-one session with the GP before contacting the pharmacy. The RP queried why people required covert administration and copies of covert administrations sheets were scanned onto the computer for reference. Advice on how to mix the medication with food or beverages was also provided.

The RP was not fully aware of the change in guidance around pregnancy prevention for dispensing sodium valproate. He was informed by the inspector and agreed to complete a Continuing Professional Development cycle on the update. The RP said that people who the pharmacy supplied medicines to did not fall in the 'at-risk' group. Sodium valproate was dispensed in its original pack.

The pharmacy dispensed all high-risk medicines in their original packaging. For people taking warfarin the pharmacy tried to speak to the care home to confirm details of the last INR check. The RP said that he had completed an NHS audit on warfarin use.

Deliveries were carried out by the delivery driver or dispenser. Team members 'checked-in' medication with care home staff; this involved going through all patients' medicines (bulk and blister packs) to ensure they were all accurate. However, for infection control due to the Covid-19 pandemic some care homes had stopped this and checked the medication after it had been delivered. The pharmacy had delivery record sheets on which the number of items for each person were marked as well as if there were any fridge lines or CDs. Drivers had been provided with PPE and hand sanitisers. Bulky medicines were stored in clear plastic bags or totes and labelled with the person's details. This also helped confirm items with the carers.

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 medicines. CDs were kept securely.

Date checking was completed regularly. The pharmacy had been divided into 12 sections which were checked when it was quiet. The pharmacy had also recently checked the dates on medicines when the dispensary had been rearranged. Short-dated stock was marked with stickers. There were no date-expired medicines found on the shelves checked. Records for date checks were kept. Out-of-date and

other waste medicines were disposed of in the appropriate containers which were kept separate from stock and collected by a licensed waste carrier.

Drug recalls were checked by the RP on the MHRA's website, but there was no record or audit kept of any action taken. So, this could make it harder for the pharmacy to show what action it had taken in response. The RP gave an assurance that he would subscribe to receive emails from the MHRA using the pharmacy email account which could be accessed by a few team members.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it maintains its equipment well.

Inspector's evidence

The pharmacy had a range of clean glass calibrated measures available. Tablet counting trays were available. Up-to-date reference sources were available including access to the internet. The pharmacy had a large medical fridge of adequate size.

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.