General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Baxter Healthcare Ltd.;, Salthouse Road, Brackmills Industrial Estate, NORTHAMPTON, Northamptonshire, NN4 7UF

Pharmacy reference: 1035483

Type of pharmacy: Closed

Date of inspection: 19/08/2024

Pharmacy context

The pharmacy provides a homecare medicines service which involves delivering ongoing medicine supplies for people who require dialysis and nutrition bags direct to people's homes. All of the treatments are initially prescribed by hospital prescribers. Some aspects of the service, for example nursing care, are not regulated by GPhC. Therefore, we have only reported on the registerable services provided by the pharmacy. The pharmacy is located in an industrial unit and the premises is not open to the public. It is one of four homecare pharmacies owned by the same company.

This inspection is one of a series of inspections we have carried out as part of a thematic review of homecare services in pharmacy. We will also publish a thematic report of our overall findings across all of the pharmacies we inspected. Homecare pharmacies provide specialised services that differ from the typical services provided by traditional community pharmacies. Therefore, we have made our judgements by comparing performance between the homecare pharmacies we have looked at. This means that, in some instances, systems and procedures that may have been identified as good in other settings have not been identified as such because they are standard practice within the homecare sector. However, general good practice we have identified will be highlighted in our thematic report.

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

The pharmacy carries out regular risk assessments and takes steps to manage the risks it identifies. Team members follow standard operating procedures to help them work effectively. They record and review things that go wrong so they can learn from them. And they know how to handle sensitive information to protect people's privacy.

Inspector's evidence

The pharmacy processed and dispensed prescriptions for people who had kidney failure and needed medicines for dialysis, and for people who had intestinal failure and needed nutrition to be administered intravenously via multi chamber bags (MCB). The pharmacy did not dispense any controlled drugs (CDs) or items requiring cold storage and only dispensed prescriptions received from NHS Trusts with which it had service level agreements (SLAs).

A responsible pharmacist (RP) notice was displayed in the pharmacy office area and the RP record was appropriately maintained. The pharmacy operated 24 hours a day with pharmacists working shifts as the RP for eight hours at a time. A customer service team (CST) operated from an office within the pharmacy. There was also a warehouse team responsible for moving stock in the warehouse and a quality assurance (QA) team.

The pharmacy had current professional indemnity insurance in place. A range of Standard operating procedures (SOPs) were available covering all of the pharmacy's services. The SOPs were reviewed and updated every two years, and all were currently up to date. They were kept electronically, and team members were required to read them during their induction and re-read them after any reviews or updates.

A risk assessment register was kept, each risk was given a rating based on the likelihood of it occurring, the impact if it occurred and the overall severity of the risk. The risks were divided into different categories based on the different activities, for example, for the final release of orders for kidney failure patients. The risk registers recorded the existing controls in place to reduce the chance of the risk occurring. The risk registers were reviewed every two years or if an incident occurred. The pharmacy had recently completed an audit of its services against the General Pharmaceutical Council's standards which had found good compliance.

The pharmacy team recorded near misses that were identified during the dispensing or administrative processes (i.e., mistakes they spotted before a medicine had left the dispensary). Near misses made by the CST such as incorrect details being entered were recorded electronically on a shared system so all team members could see them. A daily report was sent to the manager in the CST to review and discuss the near misses and identify any trends. The CST manager who was present during the inspection gave an example where more training was provided to a colleague who had been responsible for several near misses. Near misses made when dispensing were recorded on paper log sheets. The pharmacy manager said that the dispensary team had regular meetings to discuss near misses and share any learning. The pharmacy had also identified areas of the patient journey where most near misses occurred and added stricter monitoring and checking of items picked and dispensed from these areas.

The pharmacy manager said there had not been any recent dispensing errors (i.e., mistakes that had left the pharmacy).But if any did happen, they would be fully investigated, and an incident report would be sent to both the superintendent pharmacist (SI) and the relevant NHS trust.

The pharmacy provided all new patients with a welcome pack which explained how the service worked as well as information about how they could make a complaint or provide feedback. This information was also available on the pharmacy website. Complaints were initially managed by the customer service team (CST) and depending on the type of complaint received, they would be forwarded to the relevant team for investigation. All complaints received were added to a complaints log which was reviewed daily by the managers to look for any trends. The CST manager said that teams had monthly meetings to discuss any complaints and to identify any learning points. There was also a quarterly senior management meeting which reviewed complaints and identified any improvements that could be made. The CST manager said that a root cause analysis (RCA) was done for all complaints received. Team members in the CST received regular training to be able to help patients with any problems and could escalate any queries to a pharmacist if necessary. The CST manager regularly listened to calls in order to monitor the quality of the service and provide any feedback or further training if needed, such as how to deal with clinical queries.

People were given a four-hour time window when they could expect their medicines to be delivered. People normally had a three day ‘buffer’ supply of medication so they would not run out if a delivery was late. The pharmacy also operated 24 hours a day so same day deliveries could be made if required to ensure that a patient did not miss a dose.

Confidential material was shredded on site as soon as it was no longer needed. There was a privacy notice available on the pharmacy’s website detailing how the pharmacy handled people’s personal information. The CST manager stated that all CST team members had received appropriate GDPR training and knew how to appropriately handles people’s personal information. All CST team members had completed safeguarding training level one and the pharmacy professionals had completed level two training. There were dedicated safeguarding leads in the pharmacy and the pharmacy had details of safeguarding contacts they could reach out to if they had a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to effectively manage its workload. Team members have defined roles and understand what is expected of them. They are appropriately trained for the work that they do, and they receive regular ongoing training to help keep their knowledge and skills up to date. Team members know how to raise concerns and are comfortable raising any issues that they have.

Inspector's evidence

The workload was shared between different teams, including the dispensing team, CST, the warehouse team and the QA team. Transport and delivery of medicines was provided by separate companies. The dispensing team employed fourteen pharmacists, three pharmacy technicians, who worked as accuracy checkers (ACPT) and six dispensers. There were enough team members to manage the workload and the team was up to date with dispensing. Team members were observed working calmly and efficiently and supporting each other. The pharmacy had contingency arrangements for any staff absences which mainly involved using locums when necessary and there was a business continuity plan in case a major event occurred.

The CST was responsible for registering new people with the pharmacy, initial handling of complaints or queries, and arranging deliveries with people. The CST recorded any interactions with people electronically on the individual's patient record. The team consisted of 22 members of staff and the CST manager. They held daily meetings to share information and discuss any incidents or near misses. The CST room had screens which displayed performance indicators such as: calls waiting, calls in progress, current waiting times for inbound calls, call answering times, and dropped off/abandoned calls. This allowed the CST to monitor their workload and when necessary, more telephone lines could be opened, and team members could switch roles to help answer calls. During the inspection, calls were generally being answered immediately.

All team members completed a full induction prior to starting and completed all training relevant to their role. Each team member had an activity log that contained all areas of training that needed to be completed and this needed to be signed off by their manager. Team members completed training relevant to their roles including GDPR, confidentiality, health and safety and safeguarding training. Team members received ongoing training about the products and medicines the pharmacy supplied. The CST team also completed a GPhC approved homecare medicines training course as part of their training. Members of all teams communicated with each other verbally, via emails and during meetings to share any updates of issues within their teams to ensure the whole process ran smoothly. Team members completed an annual staff survey and were also able to give feedback about the pharmacy's internal processes both formally and informally. When questioned team members said they would be comfortable raising any concerns and would usually speak to their manager but could also escalate to the SI if necessary. Team members had regular formal performance reviews with their managers to monitor their progress.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy and well maintained. It is effectively secured from unauthorised access. And there is plenty of space for all team members to carry out their work safely and efficiently.

Inspector's evidence

All of the different teams worked within the same building and the whole building was registered as pharmacy premises. The building was split into two main areas; the office areas where the CST team worked and the warehouse where medicines were stored, dispensed, checked and loaded into vehicles for delivery. All areas of the office and warehouse were clean and tidy and well maintained. The temperature and lighting of the offices and warehouse were appropriate and temperatures in the warehouse were continuously monitored. Safety equipment was worn in the warehouse areas and there were designated walking pathways. There was plenty of floor and desktop space in both areas. The office area had toilets with access to hot and cold water and handwash. And there was a cafeteria available for staff to use.

Visitors were required to sign in when entering and exiting and were given a temporary pass which was returned when leaving. Key cards were needed to enter the offices and warehouse. There was a large car park which was gated to restrict access. The pharmacy had a website which had information about all the services it provided. The website also had contact details including the relevant telephone numbers and addresses.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team works effectively to supply the right medicines to people at the times they need them. And it takes steps to ensure medicines will be delivered on time, in good condition and fit for purpose. The pharmacy communicates well with its patients so they know when they will receive their medicines and ensures medicines are ordered in advance to prevent people running out. And it gives advice and support to help make sure people use their medicines safely.

Inspector's evidence

People had to be registered with the pharmacy before they were able to use its services. Patients were nominated by the hospitals and the Trusts then completed registration forms, which the patient signed to confirm their consent for the service. Registration forms were emailed or faxed to the pharmacy along with a copy of the prescription, and the original prescription forms were sent by post. When a new application was received, the prescription was clinically screened by a pharmacist and the CST used the registration form to create a patient record. The process of registering a new patient usually took less than an hour. The CST then called the person to explain how the service worked and confirmed the person's contact details. The CST manager explained that first contact with the person was always by phone call. The person was then sent a welcome pack with further information about the pharmacy and the service, this was usually done by post or email. Welcome packs were only available in English and there was no option for braille or large text versions, which meant some patients may find it difficult to understand. However, some members of CST were multilingual. Pharmacists were available to provide counselling to people about their medicines and answer any clinical questions. If a clinical question could not be answered by anyone at the pharmacy, the person would be referred back to the trust for further information. If the first supply was urgent, the patient could be registered, a delivery time agreed, and the prescription dispensed and delivered all in the same day. The CST routinely called people to confirm that they had enough stock of medicines and ancillaries at home. People could also download an app which they could use to update the pharmacy about their stock levels. All information and communication with people including calls and stock levels were recorded on the patient records.

To order repeat prescriptions, the pharmacy had to contact the relevant trust about 4-8 weeks before the prescription was due. Reports were run automatically that showed which people's prescriptions were due to be ordered. Prescriptions were then received by post, and when they came in, they were checked by the CST to confirm that all prescriptions requested had been received. The pharmacist then carried out legal and clinical checks and updated the patient record, before they were dispensed. If there were any queries with prescriptions or missing information, the relevant prescriber at the trust would be contacted. The pharmacy usually waited 3-4 hours for a response before chasing. When dispensing was complete the CST called the patient to confirm the delivery and check how much medication and ancillaries that they had at home.

The stock in the warehouse was separated into two categories, larger whole items such as dialysis bags were stored in dedicated areas on pallets. Smaller individual items such as vitamin ampoules were stored in boxes. The warehouse team picked the necessary items against verbal instructions given by headset and did not refer directly to the prescriptions. For larger orders forklift trucks were used to pick the items. The items were then brought to the pharmacy area where dispensing labels were attached by a qualified dispenser. The assembled order was then checked by a pharmacist or ACT who would

stamp all items to confirm that they had been checked. The order was then handed over to the transport company for delivery to the patient. The warehouse team members signed a sheet to confirm they had picked and checked the items, but there was nowhere on the sheet for the dispenser to sign to confirm their role so the audit trail was incomplete. After the inspection the pharmacy confirmed that the sheet had been amended and that the dispenser's signature was being captured.

As part of the SLA with the trusts, the pharmacy also supplied ancillary items, such as syringes, that patients needed in order to safely administer their medicines. These were not ordered on the prescriptions but were added to the orders at the pharmacy's discretion.

The pharmacy used a separate company to provide its delivery service. The CST called the patients to agree a delivery day, and the trust was also informed. On the day of delivery patients were sent a text with a four-hour window in which the delivery would arrive. The delivery vehicles were all temperature monitored and if a vehicle temperature went out of range the medicines would be returned to the pharmacy and would be quarantined and assessed. The pharmacy received up-to-date information about deliveries, including any significant incidents such as vehicle breakdown. If there was a failed delivery, the item(s) would be brought back to the pharmacy. A note would be put through the door explaining that delivery had been attempted and the patient would be contacted by the CST to arrange a redelivery. The pharmacy manager explained that all failed deliveries would be redelivered urgently to ensure people did not run out of their medicines but said that the number of failed deliveries was very small. A different delivery company, with specialist vehicles, was used for some patients who lived in remote or hard to reach areas.

If the pharmacy did not have all of the medicines available that had been prescribed, a note was put in the delivery box to explain that the person was owed some medication. When the required stock arrived and was scanned into the pharmacy's stock system, an order would automatically be generated for the pharmacy dispense the owing which would be sent to the person as an urgent delivery. The CST would also telephone the patient to confirm when they would be available to take delivery of the owing. If there were any long-term medicine shortages, the pharmacy would liaise with the Trust prescriber and agree a plan for ongoing treatment before any changes were made. The pharmacy would also liaise with the trust regarding any new training that may be needed if the patient needed to use a different medicine or medical device.

The pharmacy's computer ran regular reports forecasting how much stock was likely to be used and stock orders would be placed accordingly. All stock items had minimum quantity levels that were sufficient to allow for a sudden increase in orders. Drug alerts and recalls were received by email to both the SI and the QA team. The QA team would check to see if the alerts affected any medicines the pharmacy supplied and take action as appropriate. All alerts were archived electronically after being actioned.

Medicines were stored neatly on the shelves in the warehouse. When large items of stock arrived, they were logged onto the system with their batch number and expiry date. Products were stored together in the warehouse by batch number so every individual batch had their own assigned place in the warehouse. Smaller products and ancillaries were logged in the same way and were stored in dedicated boxes in the warehouse. Every storage location was assigned two codes to for people to confirm they were at the right section when picking the items. All medicines were checked electronically when being picked and if the item expired in less than 90 days, the system would prevent it from being dispensed and the items would be removed from stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the equipment it needs to provide a safe and efficient service. It uses its equipment in ways that protect people’s privacy.

Inspector's evidence

All teams had access to the internet for any online resources they needed. A large number of computers were available for team members to use which were all password protected, backed up regularly and encrypted. This meant more team members were able to take calls when the call volume increased. Headsets were available to allow for conversations to take place in private. All electrical equipment had been tested in November 2023. The was an IT team which was available 24 hours who could assist with any IT issues and a dedicated onsite IT team which operated during working hours.

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.