General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Healthcare At Home Ltd, Fifth Avenue, Centrum 100, BURTON-ON-TRENT, Staffordshire, DE14 2WS

Pharmacy reference: 1084907

Type of pharmacy: Community

Date of inspection: 26/11/2020

Pharmacy context

Healthcare at Home operates across the UK delivering specialist medicines and ancillary equipment to people in their home. Supplies are made against prescriptions issued from NHS Trusts and clinics across the UK. The medicines supplied are used to treat a range of medical conditions such as cancer and rheumatoid arthritis. Healthcare at Home has a compounding unit on site for the preparation of chemotherapy products. This was a targeted inspection after the GPhC received information that some people using Healthcare at Home's services experienced delays to receipt of their medication. All aspects of the Healthcare at Home service provision were not inspected on this occasion. The inspection took place during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	Healthcare at Home doesn’t fully identify and mitigate the risks to ensure the continued safe and effective delivery of its services. It doesn't always have robust contingency planning, particularly when introducing and implementing changes such as information technology (IT) system updates. This means people don't always receive the delivery of their medicines before they miss a dose. And this may cause them harm.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Not assessed	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	Some of the information Healthcare at Home holds about the medicines people have at home is not accurate. And it doesn't have suitable arrangements in place to ensure changes to its systems and processes do not impact on the safe and effective delivery of services. This means there is a risk that people experience delays to the receipt of their medicines and may miss their prescribed doses.
5. Equipment and facilities	Not assessed	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

Healthcare at Home doesn't fully identify and mitigate the risks for the consistent safe and effective delivery of its services. It doesn't have robust business contingency planning to ensure people always receive a delivery before they miss a dose of their medication. It effectively manages the risks associated with the COVID-19 pandemic. The teams at Healthcare at Home are good at recording and monitoring mistakes they make, to identify trends to learn from. And they share some learnings across the teams, but they miss certain opportunities to enable team members to learn from each other's mistakes. People mostly have the opportunity to raise concerns but due to restricted ways to communicate with Healthcare at Home this is sometimes difficult.

Inspector's evidence

Healthcare at Home was inspected during the COVID-19 pandemic. There was a one-way system into the pharmacy department and Personnel Protective Equipment (PPE) in the form of gloves and masks were available at the entrance into the building. All Healthcare at Home team members wore PPE face masks, and most team members wore an outer PPE over suit. The PPE over suits were stored in one area and arranged in size order. The different size suits were stored in different areas, greater than two metres apart to help with social distancing. A one-way system was in place for putting the suits on and removing them. The GPhC inspectors wore the PPE over suits for inspecting the pharmacy and warehouse areas. Dedicated bins were used to place the suits in to after removal. Healthcare at Home had set-up several groups from different teams to plan and respond to the impact from the pandemic. These groups included a team focusing on people using its services who were self-isolating and the arrangements needed to deliver their medication. Another group focused on the impact of the pandemic on the Healthcare at Home nursing team who attended people in their home. And the support the nursing team needed. Arrangements had been made for several Healthcare at Home teams to work from home including some pharmacists and pharmacy technicians. This meant these pharmacy team members could be called upon to cover if a dispensary team member was tested positive for COVID-19 or had to self-isolate. The pharmacy had moved the labelling process from the main dispensing area to the first floor to allow for better social distancing in the dispensary. The main dispensary provided space to help team members adhere to social distancing requirements. The workflow in the dispensary meant that team members had their own workstations and did not need to cross each other’s paths. The prescription orders and medicines were passed along the dispensing benches or moved along on trolleys.

Healthcare at Home had a wide range of up-to-date standard operating procedures (SOPs) that provided the teams with information to perform tasks supporting the delivery of services. Several SOPs had been reviewed in December 2020.The SOPs were developed by a dedicated Healthcare at Home team and signed off by the Superintendent Pharmacist. The SOPs described the roles and responsibilities of the team. The SOPs were read by team members and senior team members monitored compliance with the SOPs.

At the beginning of October 2020 Healthcare at Home released an IT upgrade designed to amalgamate different IT platforms into one IT system. Healthcare at Home had identified the use of different IT platforms was one of several factors linked to the risk of disruption of an effective delivery of services such as people experiencing delays with the supply of their medicines. The IT upgrade was led by a

Healthcare at Home project team and an external agency who continued to provide support. The project had several go-no-go criteria and a risk register. Some senior members of the pharmacy team were part of the project team. Several pharmacy team members were trained to support other team members with the small changes to the pharmacy processes as a result of the IT upgrade. The IT upgrade included the introduction of a full bar code scanning system to track and trace all prescription orders up to the point of a successful delivery to the person.

Soon after the launch of the IT upgrade the system became unstable and was working slower. This had an impact on the processing of prescription orders and caused a backlog of orders in the system. Due to the volume of orders processed on a daily basis this affected the delivery of some people's medicines. Text messages that were usually used to inform people of the delivery of their medicines were not sent. Healthcare at Home reported over this period there was a significant increase in failed deliveries each day. Several people raised concerns with the GPhC about delays with the receipt of their medication. And were concerned they may not receive their medication in time for the next dose. The people who contacted the GPhC expressed frustration with issues they regularly faced in contacting Healthcare at Home to ask about the delivery of their medicines. Several people received their medication after their dose was due and a couple had to attend hospital to receive their medication after missing their prescribed dose. At this time Healthcare at Home experienced a large increase in the volume of calls from people. The large number of incoming calls resulted in people experiencing difficulties in contacting Healthcare at Home. And had an impact on the number of outgoing calls the Healthcare at Home teams could make to people. Healthcare at Home didn't have adequate contingency arrangements to reduce the impact on people using its service.

Healthcare at Home reported many of the causes of the IT issues experienced after launching the upgrade had not been identified during the testing phases. The leadership team identified that the testing stages of the upgrade should have been more robust by looking in greater detail at what could have gone wrong, before progressing to roll out. In response to the IT issues the Healthcare at Home senior leadership team met regularly to discuss what went wrong and to also identify what had worked well. Senior members of the pharmacy team were invited to provide information for these meetings. However, not all of the issues resulting from the IT upgrade had been shared with senior pharmacy team members. For example, some senior pharmacy team members were not aware of an error with text messages sent to people. Healthcare at Home was working on changing its continuity plan to prevent people using its services being impacted in the same way in the future. This included delaying the launch of the next IT upgrade which would be rolled out using a small group of people in a particular therapy group and better liaising with a small number of NHS Trusts. Healthcare at Home identified this method of introducing the next upgrade would offer flexibility to increase or decrease the number of people whose supply of medicines would be part of the upgrade. And allow the current system to work alongside the new system.

Whist the IT upgrade had not introduced a significant change to the processes followed by the Healthcare at Home pharmacy team, the issues arising after going live had an impact on the pharmacy work streams and the team’s workload. The pharmacy team found that orders arrived at the pharmacy at a slower rate, were often in small or large volumes and were sent at different times during the day. This was in contrast to the usual process that provided the pharmacy team with a structured approach and information on the volume of prescription orders to be processed, to help team members plan the workload. As a result of the varied receipt of prescription orders the pharmacy team often had to manage a surge in prescription orders due out. This was hard work for the pharmacy team and had a knock-on effect on the efficient workload.

Not all the delays in the delivery of people's medicines were attributed to the upgrade in the IT system.

The management team had identified errors that occurred when inputting dates about a person's delivery schedule into the system. This was often a specific individual human error. These errors relied on a team member noticing or Healthcare at Home being informed by the person or the NHS trust when a delivery didn't arrive. The pharmacy team had developed an end of day reconciliation process to identify prescription orders that were ready for delivery. And to identify prescription orders that were not at the stage of processing they should be. This triggered a response from a trouble shooting team to ensure the order was ready for delivery. It was not known if the Healthcare at Home management team had reviewed or audited the end of day reconciliation process to ensure all people who had not received their scheduled delivery were identified. It was also not known if this process would pick up prescription orders for people when the error occurred earlier in the process such as entering an incorrect scheduled delivery date. Evidence was not seen such as an audit of whether the changes to the IT system and the process of reconciliation had reduced the risk of these errors and any serious consequences for the person due their medication.

A data analyst system was being developed to identify people who had a delivery due out. The system would check the person's last delivery and care routine to predict when the next supply was due. And it would provide information throughout the day on completed deliveries and failed deliveries. Senior managers would use the data to chase-up outstanding deliveries and reschedule failed deliveries. The data would also show cancelled deliveries which would trigger the senior team member to look into why it was cancelled to ensure it was a valid reason and not an error in the system.

The pharmacy kept a record of errors that occurred during the dispensing of prescriptions, known as near misses. Sometimes a pharmacy team leader discussed the error with the team member involved and provided feedback to help the team member prevent a similar error. On these occasions the team member involved completed a reflective practice form that included comments from the team member's line manager. This detailed the number of near miss errors over a month and the type of error. The form asked the team member to consider several points including what caused the error and whether their own dispensing process needed reviewing. The form also asked the team member if they had any ideas for a change in the team's procedures to help prevent the same error happening again. Examples of completed forms showed one team member identified that having additional responsibilities had contributed to their errors. This was also recognised by their manager who was to review the team member's role and responsibility. Similar forms were used by members of other Healthcare at Home teams following patient safety incidents. On other occasions team members received an email of their errors for their own self development. Team members received an email detailing their individual near miss errors. On some occasions when there had been several errors made by the same team member a manager would discuss their errors with them. But mostly the team member would undertake their own review and follow-up.

Usually the first contact Healthcare at Home had about patient safety incidents was through the customer and patient service team (CPS) who passed it on to the relevant team members including the pharmacy team. The pharmacy management team used the information from the error records to produce reports to help identify trends. Occasionally an overall review of the errors at a team level took place and the pharmacy team would receive an email or hold a team briefing about a patient safety incident to share learning. The pharmacy team members on these occasions would sometimes be asked for input and suggestions to help prevent the error from happening again. The root causes from the review were represented on a bar chart along with the results from the previous month to identify increases or decreases in errors. The review from November 2020 revealed common errors included labels with the incorrect quantity printed on and the wrong quantity of medicine dispensed. The review identified causes of these errors included a change in the delivery frequency on the prescription and the order forms being raised incorrectly by a member of the customer service team.

Errors involving other Healthcare at Home teams included failed or missed deliveries. A clearly signposted area in the warehouse held picking errors so these could be investigated. The warehouse team did not log its own errors. The dispensary team informed the warehouse team of the picking errors they identified. And recorded the errors on to the electronic log used by Healthcare at Home for all other errors.

In addition to the activity of the senior pharmacy team Healthcare at Home had a trouble shooting team who led on the investigations into safety incidents. This team identified the teams and team members involved and used tools such as CCTV to identify where the error happened. The trouble shooting team provided information to the Healthcare at Home quality team as part of the corrective and preventative actions (CAPA) process.

Each team within Healthcare at Home, including the pharmacy team, received monthly data trends to look for root causes. These were discussed as a management team. But it did not share these data trends or the learnings with the team members as a whole so they could learn from other's mistakes. The Healthcare at Home management team which included the pharmacy operation manager held weekly patient safety meetings to discuss and analyse all issues that had impacted on people using Healthcare at Home services. Following one such meeting CPS team members worked closely with pharmacy team members and found issues such as prescription orders being submitted against expired prescriptions. A report was created, to be used daily, to ensure invalid prescription orders did not reach the pharmacy team.

Healthcare at Home recognised that communications and contact had been difficult for people and NHS Trusts during and after the issue arising from the IT upgrade. It recognised that whilst NHS Trusts had been informed about the IT changes in a bulletin more could have been done to engage with the NHS Trusts upfront to work together to ensure people did not go without their medication. The GPhC received several reports from people and NHS Trusts of constant difficulties with contacting Healthcare at Home to raise a concern or report a delay with the supply of medication. Healthcare at Home identified that telephone calls remained the main method of communications and as a result was often vulnerable to increased use such as people attempting to contact Healthcare at Home to ask about the delay to receipt of their medicines. Following the difficulties that occurred after the IT upgrade Healthcare at Home increased the resources to support the telephone lines. This had reduced some of the waiting times but a few people continued to experience delays with contacting Healthcare at Home. In response Healthcare at Home was developing plans to increase the communication tools available for people to contact Healthcare at Home. The additional tools included two-way text messaging, email and the use of the chat box on the website.

Principle 2 - Staffing ✔ Standards met

Summary findings

Healthcare at Home has a large pharmacy team consisting of team members with a range of skills and experience to support the safe and effective delivery of services. They have opportunities to develop their skills and take on additional responsibilities. Some team members are inexperienced and have a temporary contract and the more experienced team members support them and each other in their day-to-day work. They have opportunities to make suggestions to improve the way they work.

Inspector's evidence

During the inspection the inspectors met with the Superintendent Pharmacist, the warehouse manager, the dispensary operations manager and a pharmacist working in the role of head of clinical fulfilment. The inspectors also spoke to members of the pharmacy team and the warehouse team. The Healthcare at Home pharmacy team consisted of around 65 full-time members with 25 additional temporary team members who were employed to support the team manage the impacts from the IT upgrade and to help clear the backlog of work. The pharmacy team consisted of pharmacists, pharmacy technicians, accuracy checking technicians (ACTs) and NVQ2 qualified dispensers. A proportion of the team was temporary and inexperienced to Healthcare at Home processes. New team members completed training prior to starting to use the Healthcare at Home system for processing prescription orders. New ACTs did not start checking prescriptions until they felt competent to do so. Experienced members of the pharmacy team were available to help new team members with any queries. In addition to the team in the dispensary a group of pharmacists worked in an upstairs office helping with the processing of people's orders. A separate pharmacy team also based in the upstairs office generated the prescription labels. A group of pharmacists were based in the main office site supporting teams such as CPS. The pharmacy team worked closely with other Healthcare at Home teams to manage potential issues that could impact on service delivery and the experience of people using the services.

The usual system deployed by the dispensary team meant that once a day's orders had been completed the team could start the next day's orders. Since the new IT system had been installed and the issues this had caused Healthcare at Home had taken on additional resource to clear the backlog, then get ahead with the workload and create a buffer.

Pharmacy team members were provided with opportunities to develop their career. The dispensary operations manager had worked for Healthcare at Home for several years and had recently been promoted to this role from working in the dispensary, so was familiar with the processes. The dispensary operations manager had received support from team members in similar roles and knew who to ask for help if needed.

Healthcare at Home team members were provided with regular training including new or updated SOPs. A monthly town hall meeting was held with the pharmacy team when team members were asked to share issues and concerns that were either managed within the team or shared with Healthcare at Home management team to resolve. Recent examples included the issues around electronic prescriptions not being sent or delayed. Discussions related to this matter included suggestions for senior pharmacy team members to liaise with external organisations such as NHS Digital. Some senior members of the pharmacy team were part of the project team for the IT upgrade. Several pharmacy team members were trained to support other team members with the IT changes that affected the

pharmacy. Some members of the senior pharmacy team were involved with the testing phases. And more team members would be involved in the roll out of the next IT upgrade which would have a large impact on the processes and workload of the pharmacy team than the previous upgrades. Senior members of the pharmacy team had suggested that the roll out of the next IT upgrade should involve more feedback from pharmacy team members on issues they were not happy with and more emphasis on 'what if' scenarios. The pharmacy team would also receive training on how to deal with the system when it did not work.

Principle 3 - Premises ✔ Not assessed

Summary findings

This principle was not assessed because the inspection focused on other key areas

Inspector's evidence

This principle was not assessed because the inspection focused on other key areas

Principle 4 - Services **Standards not all met**

Summary findings

Healthcare at Home provides services to support people's health needs. But some of the information it holds about the medicines people have at home is not accurate. And it doesn't have suitable arrangements in place to ensure changes to its systems and processes do not impact on the safe and effective delivery of services. This means there is a risk that people experience delays to the receipt of their medicines and may miss their prescribed doses. Healthcare at Home gets its medicines from reputable sources and it stores and manages them properly.

Inspector's evidence

Healthcare at Home provided a range of advanced services delivered to people in their home. The services provided by the pharmacy team included supplying medication and ancillary items such as sharps bins to people, carers and nurses. Prescriptions were supplied from NHS Trusts and clinics across the UK. Most prescriptions were for specialist medication to treat a range of medical conditions such as rheumatoid arthritis and cancer treatments. Healthcare at Home had a team of nurses who attended people's homes and provided support for people new to the service by explaining how to store and administer the medication. Healthcare at Home divided the medicines it supplied into three priorities based on the medical condition being treated, the medicine itself such as its stability and the urgency of supply. Around 14% of people were in the Priority 1 status which included oncology treatments and transplant medicines. Another 14% of people were in the Priority 2 status, including HIV and endocrine metabolic medicines. 72% of people using Healthcare at Home were in the Priority 3 category with medicines for dermatology and rheumatology conditions. This enabled Healthcare at Home to manage and monitor the processing of the prescription orders for these priority groups.

The teams at the NHS Trusts assessed people before referring them to the Healthcare at Home services to ensure this method of receiving their medicines was suitable for them. A specific record and account were created when the person started using the service. The initial contact between Healthcare at Home and the person was used to confirm their personal details and to provide the person with an explanation of how the service worked. The appointments for the nurse visits were booked at this point and delivery dates and delivery arrangements agreed. This contact was managed by the CPS team and the information recorded on the person's account. Healthcare at Home acknowledged that the key relationship for people was with their consultant who oversaw the management of their medical treatment. Healthcare at Home encouraged people to contact their consultant or the NHS team when queries arose about their medication and prescriptions as well as contacting Healthcare at Home. People were advised of this as part of the first induction call by a member of the CPS team or at the first visit by a Healthcare at Home nurse.

The prescription order process usually started around eight weeks before the delivery was due. The prescription for the next cycle of supplies was either automatically sent to Healthcare at Home or the team at Healthcare at Home requested the prescription. The CPS team usually contacted the person two weeks before the delivery date to confirm their medication, the delivery details and agree the delivery date. The process detailed that the person received a text message 48 hours before delivery to confirm the delivery date and received another text the evening before the delivery advising the person

of the delivery time window. Recently some of these text messages had not been received and people telephoned Healthcare at Home, putting strain on its communication network. Deliveries were planned two weeks before the person needed to start their next supply as the system was set up so people had two weeks buffer stock of their medicines. Or in accordance with the instructions from the NHS Trust. The Healthcare at Home CPS team recorded the buffer stock on to the person's record and usually confirmed the availability and quantity of buffer stock when contacting the person to arrange delivery. There were arrangements if a person did not understand about their buffer stock to refer to one of the pharmacists. One outcome from the investigation after the IT upgrade issues was that in some cases the accuracy of the information about buffer stock was not correct and people had been without their medicines. This was partly as situations such as previously failed deliveries had not been factored in. Recording and maintaining the accuracy of buffer stock information can be challenging and Healthcare at Home had plans to improve their systems. Healthcare at Home was contacting people to confirm the amount of medicines they held. Part of the IT upgrade was the introduction of a Smartphone App to provide people with an opportunity to update Healthcare at Home with the quantity of buffer stock held.

Prescriptions were written by prescribers at the Trust and each prescription usually authorised several supplies over a specific period of time. The frequency of supply and the quantity of medication was dependent on several factors including the dose and stability of the medication. The Healthcare at Home prescription services team and the pharmacy team handled prescriptions received at Healthcare at Home and transcribed them on to the system. Many prescriptions were written on paper templates that differed between Trusts. Healthcare at Home reported this method of sending prescriptions often caused problems such as delays with receipt of the prescriptions when people didn't attend their appointment or postal delays. The Healthcare at Home systems and processes did not identify missing prescriptions for orders that were due. And on several occasions the lack of a prescription was only spotted when a patient safety incident arose such as the person not receiving the medication on time. Healthcare at Home planned for the IT upgrade to address this problem by introducing a system to identify early on in the process when a prescription had not arrived.

The Healthcare at Home prescription management team dealt with administrative task such as registering a person on to the service, requesting prescriptions and scanning received prescriptions on to the system. The Healthcare at Home pharmacy team, in addition to dispensing the prescriptions, dealt with prescription queries and chasing responses. This team consisted of qualified dispensers or trainee NVQ2 dispensers. This meant that clinical conversations about a person and their prescription could take place as soon as possible in the processing of orders. The Healthcare at Home system enabled a reminder to be set for a team member to chase-up any prescriptions that were not received from the NHS trusts at the time they were expected. This would result in the team member emailing and telephoning the NHS trust. Healthcare at Home continued to request prescriptions from the Trusts when they were not received. And outlined to the Trusts the urgency of the prescription relative to when the person's next delivery was due.

The IT upgrade introduced a hand-held device for the team in the warehouse to use, which used a barcode system. The barcode on the medicinal stock was scanned as part of the booking-in process in the warehouse. And the stock was scanned again when placed into its specific storage section. The warehouse team member responsible for picking prescription orders scanned the barcode on the order, the barcode on the shelf and the barcode on the product to confirm the correct item had been selected. The handheld device alerted the team member selecting the medicinal product to a picking error. The same barcode system was used for the dispensing of the prescription order, the delivery of

the person's medication and the receipt at their home. This provided Healthcare at Home with an end-to-end audit trail. The warehouse team members found the system enabled them to efficiently complete stock checks and picking errors were easily identified.

The Healthcare at Home teams used the upgraded system to know the availability of medicine stock for each person's prescription and to monitor stock levels. This meant Healthcare at Home could respond to demands on stock levels such as changes to the quantity prescribed. The initial check of prescriptions received at Healthcare at Home included whether the medicines were in stock. This gave time to order the stock or to deal with manufacturer's supply problems. At the time of the inspection this was a new system and there was no information available to know the impact this upgrade had on the processing of prescription orders and to ensure deliveries to people were on time. When Healthcare at Home experienced issues with stock availability it usually contacted the NHS Trusts to advise of the stock issue. And to seek confirmation that an alternate medicine such as a different generic brand could be supplied. During the dispensing process team members would speak to a pharmacist regarding issues such as out-of-stock medicines.

The pharmacy team had a system to prioritise dispensing of the prescription orders. Priority One prescriptions were dispensed in the morning as the products for these prescriptions were usually picked by the warehouse team the evening before so they were ready to dispense. The system enabled urgent prescription orders to have their status changed from standard processing to a higher, urgent level which was picked up and acted upon by the pharmacy team. This information was flagged and added to the dispensary reconciliation data used at the end of each day to identify outstanding orders to be processed. The pharmacy team usually worked on a same day process which aimed to have prescription orders dispensed for delivery the following day. The process allowed some flexibility with workload to enable the pharmacy team to plan ahead. The dispensary operations manager dictated the release of orders and controlled how work was released, for example, a dedicated time slot was allocated for the dispensing of Humira prescriptions. But the dispensing of one particular medication could change if needed. The pharmacy team arranged for complex prescriptions to arrive in the dispensary in the morning because these prescriptions sometimes had queries that needed to be addressed. Oncology orders were dispensed by a dedicated team in a specific area of the dispensary as the medicines for these prescriptions tended to be fast-moving lines. The oncology team included pharmacists who approved the prescriptions and who completed the final check of the prescription.

The pharmacy team included an administration team who managed queries with prescriptions. The queries were flagged on to the system and colour coded in order of priority and the urgency for a response. The flag named the team member responsible for managing the query. For example, naming a pharmacist to manage a query so there was a healthcare professional contacting another healthcare professional to resolve the query. The pharmacy team used the flag system to track these queries. However, all the queries raised by the dispensing team responsible for generating labels were written on slips of paper and sent to the pharmacy administration team who managed queries. This meant the query was not captured electronically on to the system and would not be flagged and tracked. This also meant that the prescription order would not be highlighted as being in the query system if a team member was checking the progress of a prescription order.

Due to changes to support social distancing during the pandemic, the generating of dispensing labels took place in an upstairs office away from the main dispensary. The dispenser generating the label reviewed the interval of supply to identify issues such as gaps in the supply of medicine to the person. If

the reason for the gap in supply was unclear the dispenser raised it with a pharmacist. The dispenser ensured all labelling records related to the person and their prescriptions were checked after any changes to the frequency of supply or after an explanation was given for a gap in supply. Any amendments to the person's records had to be authorised by a pharmacist. The generated labels were taken with the prescription orders to the main dispensary. The labels were neatly attached to the prescription order with paper clips to minimise the risk of the labels being mixed up or lost. The labelled prescription orders were captured in the dispensing IT system. This meant any missing prescriptions would be identified if they became lost.

As part of the dispensing process the pharmacy team used the bar code system to check the person's details and the medication details on the prescription against the picking list of medicines required for the prescription. And against the delivery note. This check involved the pharmacy team members scanning the bar code which brought up the image of the person's prescription. The dispensary team checked the prescription was still valid and had instalments available to supply from. And checked that the prescription order number matched the delivery note. When the medication was to be administered by a Healthcare at Home nurse a copy of the prescription with the person's name highlighted was sent with the delivery. This provided the Healthcare at Home nurse with direct access to the prescriber's instructions.

The main dispensary had separate workstations for assembly, accuracy checking and packing. Each workstation had a computer and a monitor providing the dispensers and ACTs with access to the information they needed to perform their tasks. The dispensers used baskets to separate different people's medicines. The dispensers printed the prescription orders on different coloured paper to prioritise important and urgent orders. And to ensure they completed orders for Northern Ireland for the required deadline. On one occasion a team member had caught a flight with a high priority medicine to Northern Ireland to ensure the person received their medicines before they ran out. The dispensary team had re-arranged into groups of two dispensers for each ACT which had improved workflow and efficiency. ACTs checked the pharmacist's clinical check had been completed and approved before they started the accuracy check. The system provided the ACT with details of the pharmacist who had completed the clinical check in case of queries. However, one of the ACTs was not aware of this information until it was demonstrated during the inspection.

Once the dispensing of the prescription order was complete it was sent for delivery by a dedicated Healthcare at Home delivery team. The orders had barcodes attached to the delivery container as part of the track and trace system. The Healthcare at Home team member updated the system by scanning the barcodes and this showed the stage the order was at. The system produced a manifest for each vehicle including its registration number created a depot trace route. For example, the Burton depot tubs were labelled with a route number system showing where the driver was going. The driver scanned the bar code to confirm their route. The system also provided Healthcare at Home with details of successful deliveries and provided an audit log for each point of the delivery van's journey. This enabled the teams to track the progress of deliveries and when queries arose. Each depot had two dedicated CPS team members as part of the logistics regional manager's team. The Healthcare at Home vans were installed with CCTV cameras as a safety precaution for the delivery driver and other road users. The delivery driver reported issues such as traffic delays so the person expecting a delivery could be updated.

Some people requested the delivery driver to contact them to inform them they were on their way. The

delivery drivers returned any failed deliveries to the local depot and entered the reason into the system. The medicine was kept there awaiting a re-scheduled delivery date. The process was for Healthcare at Home to contact the person three times to arrange a re-scheduled delivery date. On some occasion's deliveries were automatically attempted the following morning. But on other occasions re-scheduled deliveries had been delayed to more than five days. Due to the restrictions imposed by the Covid-19 pandemic the delivery driver did not ask people to sign for receipt of their medication. The delivery driver ensured the person answered the door and asked the person for confirmation of their details before leaving. The driver signed the manifest specifically labelled as Covid-19 so anyone querying this at a later date would know why the person had not signed for receipt. Healthcare at Home had made changes to minimise the impact of the Covid-19 pandemic. It had allocated delivery priorities to different groups of delivery teams. This meant if one delivery team was affected by Covid-19 the most vulnerable patients received their medicines. Healthcare at Home introduced a VIP order priority for people who had experienced previous issues with their deliveries. And for people who were in the Priority One group or needed their medicines urgently. The IT upgrade was planned to enable the CPS team to tag high priority people and people due a delivery that week. This would enable Healthcare at Home to verify that the person had a scheduled delivery day and formed part of the end-of-day reconciliation check. This process was only recently in place so there was little information to show whether it had an effect on reducing delayed and missed deliveries.

Medicines requiring fridge temperatures were stored in the warehouse in large walk-in fridges with several fans to maintain the correct temperature. The fridges were set-up with alarms that were triggered by fridge failures. The fridges were linked to a back-up generator to support the storage requirements in the event of equipment failure. The delivery driver scanned the fridge lines and placed them into the chill section of the delivery van where the temperature was monitored. The storage of medicines in the warehouse was well organised with stickers on the shelves that identified cytotoxic medicines. With the barcode technology, medicines involved in recalls were easily identified. However if there was an advertised patient-led recall Healthcare at Home had identified an increased pressure on the phone lines may impact the ability to make outgoing calls. This reinforced the importance of improving their communication methods.

Principle 5 - Equipment and facilities ✔ Not assessed

Summary findings

This principle was not assessed because the inspection focused on other key areas

Inspector's evidence

This principle was not assessed because the inspection focused on other key areas

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.