

Registered pharmacy inspection report

Pharmacy Name: Polar Speed Distribution Ltd, 8 Chartmoor Road,
LEIGHTON BUZZARD, Bedfordshire, LU7 4WG

Pharmacy reference: 1086907

Type of pharmacy: Dispensing hub

Date of inspection: 27/06/2024

Pharmacy context

The pharmacy provides a homecare medicines service which involves delivering ongoing medicine supplies 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 two 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 manages the risks associated with its services well. It has a thorough set of risk assessments which are reviewed and updated regularly. The pharmacy completes regular audits to help regulate and improve the services it provides. The pharmacy regularly reviews its standard operating procedures to ensure that team members have access to the most up to date policies and procedures. Team members regularly record and review any dispensing or administration mistakes, and these are frequently reviewed by management to identify trends or patterns. Team members know how to handle people's private information. And they know how to deal with any safeguarding concerns.

Inspector's evidence

The pharmacy had a responsible pharmacist (RP) notice on display and the RP record was appropriately maintained. A certificate of professional indemnity insurance was available. The pharmacy did not dispense any controlled drugs (CDs) and only dispensed prescriptions received from NHS Trusts with which it had service level agreements (SLAs).

A range of Standard operating procedures (SOPs) was available relating to all aspects of the pharmacy's services. The SOPs were reviewed and updated every two years. They were kept electronically, and each team member had their own account to access them. Team members were required to read SOPs as part of their induction and re-read them after they had been reviewed and updated. The management team could see when team members had not read updated SOPs and sent reminders if any were overdue.

A risk register was kept, containing a set of risk assessments. Each risk was given a score based on its seriousness and how likely it was to happen. The risks were divided into different categories such as the dispensing process, and the delivery process. The risk register was reviewed every six months and any updates were recorded. The pharmacy management team had monthly clinical governance meetings where any urgent or important issues around risks or the risk register were discussed and reviewed.

The pharmacy had completed a number of audits of different aspects of the homecare service it provided. An audit about missed doses had been completed earlier in the year. This found that most incidents related to delays in processing and sending of prescriptions by the hospitals or delays in transport and delivery of dispensed medicines. It found that the pharmacy service itself had been responsible for very few of the missed doses or delays. The audit made a number of recommendations, including bringing forward delivery schedules to ensure patients always had enough medicines available to last until they received the next supply, and, when possible, for the pharmacy to collect prescriptions for new patients directly from the Trusts, to avoid delays waiting for prescriptions to be posted. Both of these recommendations had been implemented and the SI said that as a result, there had been a reduction in the number of missed doses. The pharmacy had also completed an audit reviewing emergency requests it had received for mental health medicines and how the need for these could be reduced. The audit found that some mental health prescriptions had not been received within the appropriate timeframe which would lead to an emergency request being made. Recommendations included refresher training for the team responsible for receiving and processing prescriptions and contacting the prescriber if a mental health prescription had not been received within the appropriate timeframe.

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). These were recorded on paper logs, with different codes used for different error types. Incidents were always discussed with the team member involved and the records were reviewed weekly to identify any learning points. And near misses were reviewed at clinical governance meetings where the team would review the top three most common near misses and discuss how these could be reduced, for example by more training or updating SOPs. If an incident was considered to be serious, such as the wrong drug being dispensed, the team member responsible was expected to complete a reflective statement to help them learn from it. The superintendent pharmacist (SI) explained that dispensing errors (i.e., mistakes that had left the pharmacy) would be recorded on an incident report form and a root cause analysis (RCA) completed. The incident would be reviewed in the clinical governance meetings to identify any changes that may be necessary to avoid it being repeated. Details would be shared with the homecare team and the clinical team at the relevant Trust within 30 days of the error occurring. There were no recent dispensing error records, and the SI explained that no serious incidents had occurred for some time. The senior managers including the SI and pharmacy operations director had quarterly meetings with Trusts in which learning, changes and updates were shared. Operational incidents such as failed deliveries were also discussed. The SI provided an example of a failed delivery that had occurred due to outdated contact details being used. This had been shared with the Trust so the pharmacy was able to obtain updated contact details and ensure future deliveries would be made on time. The Trust had agreed to review their process to ensure that any future changes in contact details would be promptly sent to the pharmacy.

The pharmacy provided all new patients with a welcome pack which explained how they could make a complaint or provide feedback. This information was also available on the pharmacy website. Complaints were managed by the customer service team (CST) and forwarded to the pharmacy operations director, who would investigate what had gone wrong. The SI said that there had been some complaints recently about people having difficulty getting in touch with the pharmacy. As a result, the CST had reorganised shift patterns to deploy more staff during busier calling times. 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 senior management team listened to about 300 calls to the CST each month in order to monitor the quality of the calls and provide feedback or further training if needed, such as how to deal with clinical queries.

People were given a two hour time window when they could expect their medicines to be delivered. The pharmacy had identified that 97% of deliveries were made within the time window and 99% of deliveries were delivered by the day after the delivery was due. People normally had a 2-week 'buffer' supply of medication so they would not run out if a delivery was late. Performance statistics for deliveries were reviewed weekly in senior leadership team meetings.

All members of the pharmacy team had completed GDPR training as part of their induction, Confidential material was disposed of in dedicated confidential waste bins which were collected by a specialist contractor for secure disposal. There was a privacy notice available on the pharmacy's website detailing how the pharmacy handled people's personal information. All team members had completed safeguarding training and the pharmacy professionals had completed level two training. Any safeguarding concerns would be documented and raised with the Trust directly, and the pharmacy had access to details of other local safeguarding contacts and a safeguarding policy was in place.

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 pharmacy team was made up of a dispensing team and the CST. There was also a pharmacovigilance team and a stock management team. The dispensing team employed four regular pharmacists one of whom was the pharmacy manager, and one the pharmacovigilance manager. There were also three pharmacy technicians, two of whom worked as accuracy checkers (ACT) and several dispensers. The dispensary team was divided into three therapy areas: Mental health, Erythropoietin stimulating agents (ESAS), and new or other patients. There were enough team members to manage the workload and the team was up to date with their dispensing. Team members were observed working calmly and efficiently and were supportive of each other. Most team members were experienced in their roles. The pharmacy had contingency arrangements for any staff absences which mainly involved using locums when necessary. The agency they used had locums who were experienced in working within homecare settings.

The CST was responsible for registering new people with the pharmacy, handling any complaints or queries, and arranging deliveries with people. The CST recorded any interactions with people electronically on their individual patient record. The team consisted of about fifteen members of staff and the operations manager. They held regular meetings or 'huddles' 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. If the CST team received any calls relating to clinical issues, they were transferred to a pharmacist. Email inboxes were also monitored regularly by the CST and any clinical queries received by email were also forwarded to a pharmacist.

All team members completed training relevant to their roles. Newly recruited team members had an induction plan, including health and safety training and role-based induction to core duties. They were assigned a mentor and were required to be signed off against a competency framework. Team members received ongoing training from external sources including pharmaceutical companies and NHS Trusts. They also had access to an in-house online training platform and managers monitored completion and would chase up any outstanding modules or training.

Members of all teams communicated with each other verbally, via emails and during meetings. Team members completed an annual staff survey and were also able to give feedback about the pharmacy's internal processes both formally and informally and team members had no concerns about doing this. They explained that they would usually speak to the pharmacy operations director about any concerns but could also speak to the SI if necessary. Team members had regular formal performance reviews and

they were aware of the company’s whistle-blowing policy.

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 team members to carry out their work safely and efficiently.

Inspector's evidence

All of the different teams worked within the same building. The stock management team and pharmacovigilance team worked on the ground floor and the CST and dispensing team were on the first floor. All areas of the building were clean and tidy and well maintained. The dispensary area had plenty of floor and desktop space and there was enough space in the offices for the CST to work comfortably. A large temperature controlled storage area next to the dispensary was used for storing medicines that required cold storage. The temperature was monitored by several probes. And if it deviated outside of the required range an alarm would sound, and notification would be sent to managers phones.

There was a toilet with hot and cold water and a staff room. The pharmacy was kept secure from unauthorised access. Visitors were required to sign in when entering and exiting and entry was controlled through the use of key cards. There was a large car park with easy access for delivery vans.

The pharmacy had a website which had information about all the services it provided, details of the SI, and the pharmacy's registration number. The website also had contact details including telephone numbers and email addresses, so people knew how to contact the relevant team for support.

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. It stores its medicines appropriately and carries out regular checks to make sure they will be delivered in good condition and fit for purpose. The pharmacy communicates well with its patients so they know when they will receive their medicines. 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 posted to the pharmacy along with the first prescription. When a new application was received, the prescription was clinically screened by a pharmacist and the CST transcribed the information to create a patient record and scanned in the registration form and prescription. The CST then called the person to explain how the service worked. They also confirmed the person's contact details and contact preferences. The person was then sent a welcome pack with further information about the pharmacy and the service. Welcome packs were only available in English and there was no option for braille or large text versions. However, some members of CST spoke other languages. 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.

The SI said that the Trusts occasionally flagged the first supply as urgent, in which case the pharmacy would use a scanned copy of the registration form and prescription to register the patient and would dispense the prescription before receiving the paper copy. The pharmacy would also call the person to confirm their details and arrange an urgent delivery.

To order a repeat prescription, the pharmacy had to contact the relevant Trust about 4 weeks before it was due. The service level agreements said a prescription should be at the pharmacy at least 5 days before it was due to be dispensed. But in practice, prescriptions were usually received long before that. Each day, the pharmacy's computer system automatically monitored, prescription records and generated a report of ones that were due to be ordered. Trusts were contacted by email each week to order the prescriptions. But if there were any urgent prescriptions, they would be requested from the Trust as soon as possible. If there were any queries with prescriptions or missing information, an entry would be made on the person's record and the Trust would be contacted about the query. The pharmacy usually expected a response within 24 hours, after which time they would chase the Trust for a response.

Once a prescription had arrived from the Trust and had been clinically checked by a pharmacist, a picking sheet was generated. The item was then picked and given to another team member who would generate a dispensing label. Assembled medicines were then checked against the original prescription and sent for a final accuracy check by a pharmacist or ACT. The dispensed medicines were then packed and labelled for delivery. Baskets were used during dispensing to help reduce the chance of prescriptions getting mixed up. Dispensing labels were initialled by the dispenser and checker and each team member had their own login access to the patient medical record (PMR) to provide a full audit

trail.

The pharmacy used a courier service for all its deliveries. The delivery vehicles had controlled storage conditions to keep medicines at the appropriate temperature during transit. All patients were informed by phone of upcoming deliveries and on the day of delivery were sent a text with the two-hour window in which the delivery would arrive. The pharmacy received real time information about deliveries through its online portal, including any significant incidents such as vehicle breakdown. If there was a failed delivery, the item would be taken to the nearest transport depot and a re-delivery would be attempted the next day. A note would be put through the door explaining that delivery had been attempted and, where possible, the patient would be contacted by the CST to explain what was happening. The transport team produced weekly reports showing failed deliveries and the reasons why. And the pharmacy completed regular audits of delivery performance, including quality issues such as temperature deviations in vehicles or adverse events during deliveries such as vehicle breakdown. The audits were discussed during clinical governance meetings to review the reasons for failed deliveries and determine what steps should be taken to reduce the chance of similar incidents occurring again.

If the pharmacy did not have all of the medicines that had been prescribed, a note was put in the delivery box to explain that the person was owed some medication. The CST would also telephone the patient to confirm when they would be available to take delivery of the remainder. If there were any long-term medicine shortages, the pharmacy would liaise with the Trust prescriber and agree a plan for ongoing treatment.

The pharmacy had a team responsible for ordering stock. The pharmacy's computer system worked out what future dispensing would be required and generated a report for the stock team to order the relevant medicines. The team checked lead times on all items to ensure medicines were ordered in plenty of time for dispensing. The pharmacy always tried to keep a two week surplus of all stock to allow for any new patients. The stock team also liaised with manufacturers and wholesalers to manage any delays or long-term shortages of medicines. Stock was ordered from licensed wholesalers and also direct from the manufacturers. Drug alerts and recalls were received by email. These were all actioned by the stock team who would seek advice from the pharmacy team as appropriate.

Medicines were stored neatly on the shelves in the dispensary. When stock arrived, it was logged onto the computer system with its batch number and expiry date. Regular reports were run to identify medicines that were due to expire in less than 3 months, and affected stock was then quarantined. Regular manual inventory checks were also conducted to ensure accuracy of the expiry dates on the system and generated reports. There were several fridges in the dispensary to store some temperature sensitive medicines. The dispensary fridge temperatures were checked twice a day, and the temperatures recorded. If a deviation occurred, an alarm would sound on the fridge, corrective action would be taken such as moving the stock to an alternative fridge, and the incident would be recorded.

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. This meant more team members 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 September 2023.

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.