General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloyds Pharmacy Clinical Homecare Ltd, Units 3/5 Weardale Lane, Queenslie Industrial Estate, GLASGOW, Lanarkshire, G33 4JJ

Pharmacy reference: 1098350

Type of pharmacy: Closed

Date of inspection: 29/08/2024

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 and are carried out at a different pharmacy. Therefore, we have only reported on the registerable services provided by the pharmacy. The pharmacy is located in a purpose-built industrial unit and the premises is not open to the public. The Company is registered with the MHRA and holds a Wholesale Dealers Authorisation.

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 provides its services safely and effectively. It has adequate systems in place to identify and manage the risks associated with its services. Team members follow written procedures to help ensure they work safely. And these procedures are reviewed and updated regularly. Team members review and learn from any mistakes they make to improve the safety of the services they offer. The pharmacy asks people for their feedback on its services and responds appropriately. It keeps all the records required by law. Pharmacy team members know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy was one of four registered pharmacies owned by the same company which provided homecare services to people in the community. This pharmacy dispensed and delivered a range of specialist medicines to treat conditions that included Cystic Fibrosis, Rheumatoid Arthritis and Pulmonary Arterial Hypertension. It supplied these medicines to people who live in Scotland and Northern Ireland. Medicines were supplied against prescriptions issued by NHS health boards and health and social care trusts. The pharmacy's customer service team (CST) and prescriptions screening team were based at the company's main site in Harlow, England.

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that covered all its services. The SOPs explained the processes the team was expected to follow. The superintendent pharmacist (SI) and lead pharmacist maintained the SOPs on an online platform which team members accessed to read them. Hard copies were also available in a folder for ease of access. Team members were able to describe their roles and the processes they followed. SOPs had been approved by the SI in the last two years and records showed which SOPs had been read by individual team members. The SI was the director of quality and governance for the company, and held monthly meetings with the company's Quality, Patient Safety & Risk Management Committee. These meetings focussed on patient safety and risk management.

The pharmacy had a business continuity plan in place. It covered key scenarios such as failures at the warehouse, staffing shortages, and vehicle breakdown. And detailed measures to ensure that people's medicines would be delivered appropriately. The pharmacy maintained a risk register that identified the risks associated with the prescription journey. All new services, medicines or prescribers went through a drugs and therapeutics approval process prior to being progressed. This included risk assessments to identify the specific risks to providing the service and how these would be mitigated. For example, how injection site reactions would be managed in a person's home. Each risk was given a severity scoring which determined the review frequency. A recent risk assessment related to a known shortage of an injectable medicine showed measures that had been put in place to avoid people missing doses, which included increasing the frequency of supply to uniformly distribute stock. And the provision of alternative forms of administration. This had involved working closely with hospitals and nursing teams, and providing training about the therapy to ensure people could receive their medicine correctly.

The computer system recorded each member of the team that were involved at each stage of the preparation and dispensing process. Near misses were reported electronically. The pharmacy team reviewed the records monthly and generated a report which was used to identify learning points that

were then actioned and shared within the team. Recent near misses related to the wrong batch numbers being selected due to similar numbers. So a message was being displayed near the workstations reminding team members to take extra care with these. The lead pharmacist shared any trends in the company's monthly pharmacy governance forum. This provided an opportunity to share learning across the company and then communicate key points with the team members. A monthly Safer Care bulletin was sent out to share learning points from patient safety incidents across the organisation. The previous months' bulletin was clearly displayed in the dispensary and team members had signed to say they had read and understood it. A quarterly review was carried out to ensure that learning points had been actioned and taken forward. The team's latest patient safety discussion focussed on a specific incident where a person was prescribed two separate medicines and only received one. The pharmacy team had since implemented a process where bags were clearly marked with the total number of packages for each person, and the delivery teams had been reminded to look for further bags to prevent medication being left behind. The team had audited all prescriptions issued since and found there had been no re-occurrences.

The pharmacy carried out regular audits. The deputy superintendent carried out an assessment twice a year to check the pharmacy was meeting the required professional standards. The outcome was fed back to the pharmacy team, and they worked together to create an action plan to address any improvements required. The lead pharmacist had completed a recent audit to check appropriate information was recorded in patient medication records (PMR) when medicines were prescribed off license. This had identified differences in how this information was recorded, so it had been scheduled to be discussed at the next pharmacy governance forum to agree a consistent approach across the company.

The pharmacy had a complaints procedure to deal with any concerns it received, including feedback from homecare teams working in hospitals. It held meetings with some NHS health boards to review performance issues. The pharmacy's website included details of its complaint handling procedure. People contacted the pharmacy through its customer care line and all contact was recorded on the PMR. Team members demonstrated how this was clearly displayed when they accessed people's records to dispense medication. So the team was able to see any ongoing queries and interaction history. The pharmacy had recently implemented a new management system to co-ordinate drug safety reporting, complaints and incident reporting. This allowed the pharmacy to respond quickly to increased report numbers and identify themes. The pharmacy provided examples of changes it had made following feedback that it had received. For example, hospital teams had fed back that it was taking the pharmacy too long to process prescriptions which meant prescribers were being asked to supply further prescriptions before they were required. So the pharmacy had introduced optical scanning technology which had reduced the time it took to enter prescription data into the system.

The pharmacy carried out annual patient satisfaction surveys. Results were shared internally and with NHS trusts and health boards. Some patients had reported a lack of empathy from the CST. In response, the pharmacy provided training to improve call handling skills. The training had also included conflict management. The pharmacy recorded and monitored calls for training purposes, and the lead pharmacist utilised this to help team members develop. And it monitored call waiting time, call length and the number of abandoned calls to help identify areas for improvement.

The pharmacy had current professional indemnity insurance. It displayed the correct responsible pharmacist notice and had an accurate responsible pharmacist record. Team members were able to explain which activities could not be undertaken in the absence of the responsible pharmacist. The pharmacy did not supply any controlled drugs. The pharmacy's website explained how the pharmacy handled confidential data. This information was also contained in the welcome packs. All team

members had completed training on confidentiality and data protection. And they separated confidential waste for destruction by a specialist contractor.

All team members had completed safeguarding training relevant to their roles so that they knew how to recognise safeguarding concerns and how to report them. They were able to describe how they would raise a concern, and explained how delivery drivers called the transport manager at the time of delivery if they were concerned for a person. This was then reported to the pharmacy's safeguarding lead.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to safely provide the pharmacy's services. They manage their workload well and support each other as they work. Team members work well together and are able to raise concerns, give feedback and suggest improvements. The pharmacy has procedures in place to help manage the workload in the event of unplanned absences.

Inspector's evidence

The SI and the lead pharmacist were present during the inspection. There were three other pharmacists present along with a pharmacy technician working in an accuracy checking role (ACPT), and two dispensing assistants. Team members completed appropriate training for their roles, and their qualification certificates were displayed prominently in the pharmacy. They carried out ongoing training through an online learning platform and this included annual mandatory training on information governance and health and safety. New team members had regular performance reviews. The pharmacy team took part in weekly team huddles. They used these as an opportunity to discuss information shared by the SI and to plan the week's upcoming workload.

The pharmacy reviewed staffing levels regularly. Staffing levels appeared adequate for the volume of work during the inspection and team members were observed working collaboratively with each other. The team were able to raise capacity issues and the pharmacy utilised locum pharmacists and dispensers to help manage the workload when necessary. Locum pharmacists and dispensers had to read SOPs and carry out shadowed working with another team member before they could be signed off and given their own responsibilities.

Twelve warehouse operatives were employed in the warehouse team and rotated their roles, which related to storing and collecting ancillaries and medicines before they were dispensed by the dispensing team. Warehouse staff received the same induction training as other team members. They were required to read and sign SOPs relevant to their roles and received specific on-the-job training. They had six-monthly performance management reviews.

The pharmacy employed 25 delivery drivers to deliver medication to people in their homes. Delivery team members completed a two-week induction training programme when they started which included mandatory e-learning, SOP reading and data protection training. They reported to the depot manager at the end of each day to provide feedback on the day's deliveries and any issues that had arisen.

The pharmacy invited team members to complete an annual colleague experience survey. The results from the most recent survey indicated that team members found the company supportive and inclusive, and felt valued and able to contribute. And it identified areas for improvement such as career development opportunities and working across departments within the company. Team members received annual performance reviews. The pharmacists were comfortable making suggestions and raising concerns with their line managers and senior management. Team members working in the dispensary were paired with team members in the warehouse to provide a single point of contact and this allowed them to share learnings with colleagues. Team members were aware that the company had a whistleblowing policy and understood that they could contact the GPhC if they wished to raise

concerns outside the organisation. ‘Speak Up!’ notices were on display throughout the premises which allowed people to report concerns anonymously via an external confidential helpline.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, well-maintained, and secure. The premises are large and appropriate for the services provided.

Inspector's evidence

The premises consisted of a large industrial unit which was clean, spacious and well maintained. There was a warehouse area, a temperature-controlled room, two walk-in refrigerated units, a dispensary, office space and meeting rooms. Spill kits for cytotoxics were available in the warehouse area. The lighting was kept to appropriate levels and room temperatures were monitored and controlled. The dispensary had six separate clearly defined workstations for individuals to carry out dispensing and final checks of prescriptions. All areas were clean and tidy, and floor spaces were kept clear to avoid trip hazards. The pharmacy employed a part-time cleaner who worked under supervision. Team members followed a cleaning schedule for the dispensary.

Members of the public did not enter the premises. Security systems were installed and an intercom was used to manage access. Visitors were required to sign-in and were accompanied. Team members used swipe cards to access different areas. Only authorised people had access to restricted areas, such as the dispensary. Staff facilities included a kitchen area and several WCs with wash hand basins and antibacterial hand wash. The pharmacy had a website which contained information about the pharmacy and the clinical homecare service.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is well organised, with dedicated teams working well together to support the effective delivery of its services. It gets its medicines from licensed suppliers, and it carries out checks to ensure they are kept in good condition and supplied safely. The pharmacy reviews its systems and processes to help improve its efficiency and support patient safety. But the way in which the pharmacy receives prescriptions by post means there are sometimes delays that the pharmacy cannot control.

Inspector's evidence

The pharmacy premises were closed to the public. People could contact the pharmacy by telephone, email, or via its website. When people used the pharmacy's service for the first time, they completed a registration process with the team at the Harlow pharmacy. The registration process provided the pharmacy with the person's contact details and a section confirming that the hospital team had discussed the homecare service with them. Information was also available on the website. The pharmacy's telephone system had a call-back option for people to choose when the line was busy, and the CST were required to complete all call-back calls by the end of the working day.

The CST had an automatic process to request repeat prescriptions for people six weeks before their next prescription was due. If prescriptions were not received within two weeks they would chase them up. But the CST were still chasing up to 15% of prescriptions that had not arrived up to five days before they were due to be delivered. This was a significant proportion of the team's work. And it was the main reason for delays to people's medicines. Common reasons why prescriptions were delayed included outstanding blood tests and the hospital requiring further contact with people before it issued their prescriptions. The SI met with all the health boards and trusts to encourage collaboration and resolve some of the problems identified. They provided education on the prescription journey, and he believed this had improved prescription turnaround times.

The NHS trusts sent all prescriptions to the company's Harlow branch. Most prescriptions from the NHS trusts were paper prescriptions sent by post. The team at Harlow scanned the prescriptions to create a digital image for all teams to refer to. The prescription details were added to the PMR. Dosage instructions were selected from a pre-selected list for each therapy and could not be typed freely, to reduce the risk of error. The Harlow team was responsible for the accuracy of the data entered into the computer. Once the details were entered, pharmacists working remotely completed screening and clinical checks of the prescriptions before they were released for dispensing. It was only once these steps had been completed that the pharmacy could access the records and start preparing the medicines. Team members referred to a digital copy of the original prescription when dispensing. The PMR maintained an audit trail of all activity on a people's records. And team members referred to the PMR during the assembly and checking of prescriptions. For example, for details of any previous missed doses. And they used it to communicate with the CST, for example, to report any items where the full quantity was not available, so they could be placed on back order and the patient informed. Team members could see when actions had been taken by the CST. Some people required ancillary items in addition to their medication, such as needles and swabs. The CST contacted people around ten days before their medication was due and checked their current stock of medicines, what ancillaries were required and confirmed a delivery date. The pharmacy usually sent ancillary items with people's prescriptions but sent additional supplies at any time if urgent. People generally kept a two-week safety

stock of medicines following their initial supply to help avoid missed doses if medication was delayed.

Most prescriptions were dispensed and ready for delivery the day after the prescription had been received by the pharmacy. Each day the pharmacy teams knew how many prescriptions were waiting to be dispensed, which helped them manage the workload. A picking sheet was generated with a unique bar code that was scanned at each stage of the process. This helped to reduce the risk of the wrong person's record being selected and provided an audit trail showing which team members had completed each step of the dispensing process. Medicines requiring cold storage were clearly marked so they could be prioritised. And team members kept a record of the times medicines had been removed from controlled refrigeration to be labelled and dispensed. This created an audit trail to ensure medicines weren't kept out of a controlled temperature for too long. After being dispensed and checked, prescriptions were transferred to the dispatch area. Medicines requiring cold storage were packed in insulated packaging and delivery vehicles were fitted with cold storage boxes that were monitored to maintain the correct storage temperature. The pharmacy supplied medicines in multi-compartment compliance packs for a small number of people who needed extra support with their medicines. Packs were labelled so people had written instructions about how to take their medicines. These labels included descriptions of what the medicines looked like, so they could be identified in the pack. And team members provided people with patient information leaflets about their medicines.

The pharmacy had a dedicated delivery team which covered Scotland and Northern Ireland. The CST arranged a delivery date and time with people. They then received a text message the night before delivery with a two-hour timeslot. Delivery drivers used electronic handheld devices to plan and record deliveries. They obtained signatures from people at the point of handing over the prescription. And information relating to failed deliveries was sent immediately to the CST so that they could contact people to arrange an alternative delivery. And the delivery team had capacity to carry out emergency deliveries if required. Most deliveries were completed successfully. The most common reason for failed deliveries was because people weren't home to accept them. People could contact the CST to nominate alternative delivery arrangements to specific people or addresses. An urgent delivery could be arranged if necessary and if the pharmacy could not contact the patient to arrange re-delivery, they would inform the hospital team. The pharmacy had arrangements to cover remote and rural deliveries. It had a specific Royal Mail account which could be used for ad hoc deliveries. There were two Inverness-based dedicated drivers to reduce delays to deliveries in the far north of Scotland. And the pharmacy delivered to Glasgow Airport with arrangements for onward delivery to the Western Isles. The pharmacy demonstrated that successful delivery rates matched those made to the mainland.

The pharmacy obtained stock medicines from recognised licensed wholesalers and manufacturers. Medicines were stored in a temperature-controlled environment with 24/7 temperature recording and warning alerts sent to key personnel if a temperature anomaly occurred. Team members regularly checked expiry dates of medicines and the pharmacy's software automatically highlighted any medicines due to expire. Team members received alerts and recalls from the pharmacy's Quality and Governance team. They quarantined any affected stock and returned it to the manufacturer. The pharmacy's software maintained a record of individual batch numbers and expiry dates. And the CST contacted people if they had received an affected batch to organise a replacement. The team kept records of actions they had taken which meant they could respond to queries and provide assurance that the appropriate action had been taken. If people contacted the CST to report side effects, the pharmacy reported them directly to the medicine manufacturers and Yellow Card reports were also completed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its systems to suitably protect people's private information.

Inspector's evidence

The pharmacy had resources available and access to the internet to provide the pharmacy team with up-to-date information. Team members were required to access IT platforms with an individual username and password. They locked computer terminals when not in use, and this was observed throughout the inspection.

The pharmacy had two cold rooms to hold medicines requiring storage at these temperatures. The temperatures in these rooms were constantly monitored, and alarms were triggered when the temperatures went outside the accepted range. Further monitors were placed around the warehouse and dispensing areas to monitor room temperatures. The pharmacy transported medicines to people's homes using temperature-controlled vans. The vans' temperatures were monitored in real-time, and records were transmitted to the pharmacy. An alert was sent to the warehouse and logistics team if the temperature fluctuated outside the required temperature range. The pharmacy had back-up generators that switched on automatically in the event of a power failure. And a back-up internet connection was available for use if the main connection failed.

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.