General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Alcura House, Caswell Road, Brackmills Industrial Estate, NORTHAMPTON, NN4 7PU

Pharmacy reference: 1122546

Type of pharmacy: Home care

Date of inspection: 14/08/2024

Pharmacy context

The pharmacy provides a homecare medicines service which involves delivering ongoing medicine supplies direct to people's homes. Hospital prescribers initially prescribe all of these treatments. 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 in Northampton 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 suitably identifies and manages the risks associated with the provision of its services. Its team members have defined roles and accountabilities. The pharmacy completes reviews of mistakes and incidents affecting its service users and produces documented action plans. Members of the pharmacy team record things that go wrong internally so they can learn from them. And they reflect on their own mistakes so that they can improve. Overall reviews of all these mistakes i.e. near misses have happened but because they do not record them some learning opportunities may be missed.

Inspector's evidence

The pharmacy team was part of a large organisation which included a range of teams such as nursing, business development, finance, human resources, administration, warehousing, logistics and a customer services team (CST). The company had a business continuity plan in place and service levels agreements (SLA) with various NHS Trusts across the UK. As part of the homecare services the pharmacy currently supplied a wide range of medicines on behalf of NHS Trusts across the country.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) which covered all parts of the service that they provided. Team members from both the customer service team (CST) and the pharmacy team had signed relevant SOPs to show they had read and understood them. Team members were seen following the SOPs which included dispensing medicines and the final accuracy check by a pharmacy technician (ACT). When asked, the team members in the CST and the pharmacy team could confidently explain their roles. A responsible pharmacist (RP) notice was on display and RP records were appropriately maintained.

The pharmacy had a range of documented risk assessments. These were carried out when the company was considering providing a new service and also looked at risks associated with current services, such as time it took to dispense medicines and missed deliveries. There was a red list for medicines which prioritised medicines according to the risks in the event of delays. This prioritised the dispensing of oncology and HIV medicines. The pharmacy had KPIs (key performance indicators), which were constantly reviewed to make sure that they complied with their SLAs. The deputy superintendent explained that the processes they had in place meant there had been very few occasions where delays had led to a patient missing a dose of their medicine. Any missed doses were reviewed and reported to the relevant NHS Trust.

A dashboard in the CST room showed data which included the number of calls waiting from people ringing the pharmacy, average and longest waiting times. If the numbers of people waiting on the phone increased, staff within the CST were moved from other tasks to answer calls. During the inspection, average waiting times for the CST to take calls from people was under three minutes.

The pharmacy held regular performance meetings with the relevant NHS trusts to discuss any issues or problems with the current service and potential new services. The meetings were attended by the account manager from Alcura and relevant people from the NHS Trust. The deputy SI said that the meetings were positive with few issues being raised.

The pharmacy had processes for learning from dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes where they had reached the person (errors). Dispensing

errors were fully investigated and reviewed with reports sent to the relevant NHS Trust. An action plan was created to address the issues that were identified. Near misses were discussed with the member of staff at the time and were then recorded in the near miss log. One of the pharmacy team completed a weekly review of each team member's near misses. They were then sent emails with details of their near misses to allow them to reflect on them and learn from these mistakes. And their near misses were then also discussed during their one-to-one meetings. The pharmacy also aimed to complete overall reviews of the near misses every two months to look for trends and patterns. The member of staff said that following a review they had changed the way the date for deliveries were recorded to make it clearer for the logistic team. They had stopped recording these reviews in November 2023. The deputy SI agreed they would start recording these reviews again.

The pharmacy completed annual customer surveys. The feedback from the most recent had been positive and the overall satisfaction score had increased since the previous year, with customers highlighting professional staff, timely deliveries, and good communication as reasons for their satisfaction. Most of the concerns that had been raised related to delivery, communication, and prescription management. So, the leadership team were reviewing how they could improve these issues.

When patients first started using the pharmacy, they were sent a welcome pack, which included details about the service and its complaints procedure. People could also complain via the NHS Trust. The pharmacy reviewed all complaints and took action to resolve concerns. A recent complaint about a customer service issue had led to a change in structure with the introduction of an inbound call team and a dedicated trainer for the CST.

The pharmacy had an information governance policy. Access to the electronic patient medication record (PMR) was password protected. Confidential information was stored and destroyed securely. The CST asked questions to confirm that they were talking to the right person on the telephone before discussing medication details. Professional indemnity insurance was in place. Pharmacy team members had completed safeguarding training, relevant to their roles and responsibilities. When questioned, a team member explained the signs of concerns he would look for and knew how to deal with them and who to report them to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s team members manage the workload within the pharmacy effectively. They receive the training they need for the jobs they do. And they know how to provide feedback to help improve the pharmacy’s services or raise concerns if needed.

Inspector's evidence

During the inspection, the pharmacy team and the CST effectively managed their workload. The dispensary team had three pharmacists, nine pharmacy technicians, six of whom worked as accuracy checkers, thirteen dispensing assistants, three trainee dispensing assistants, and seven packers. The CST had a total of eighty people split between the patient services team and the customer experience team. Dispensers completed a bespoke training course that reflected the nature of the pharmacy's business. A CST member explained that they had to complete training in a therapeutic area before joining the team that received calls for that therapy, and also completed customer service training. They were able to explain when they would refer a call to the pharmacy team and said that the CST had protected training time. The pharmacy team had weekly continuous professional development with that week's training on a new therapy area. New members of staff were required to complete a robust induction plan and were required to be signed off against a competency framework.

There was an annual staff survey. In response to the previous staff survey the structure of the organisation had changed and the current survey, which was still being reviewed, indicated that staff were much happier with the new structure. Members of the team said they had regular one-to-ones with their manager and an annual review. They said they were able to give and receive feedback. As a result of feedback, a pharmacy team member said that labelling codes had been amended which had reduced labelling errors. Staff said they were supported in their development with one team member explaining their progress through various roles in the organisation.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are suitable for the services it provides. And the pharmacy has appropriate arrangements to prevent unauthorised access.

Inspector's evidence

The pharmacy premises was in a large industrial unit on an industrial park. It was not open to the public. People visiting the site were required to sign in at the reception. The CST team worked in a separate room from the pharmacy team, the room was a reasonable size. The dispensary was also a reasonable size for the workload. It was clean and tidy, and there was enough space to store medicines and undertake dispensing activities safely. There was air conditioning to keep room temperatures at a suitable level, and hot and cold running water was available. Unauthorised access to the pharmacy was prevented during working hours and when closed. The pharmacy’s website included appropriate information about its services and contact details.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy services are managed to help make sure people receive their medicines safely and on time. The pharmacy gets its medicines and medical devices from reputable sources. Members of the team store the medicines appropriately and take the right action if medicines or medical devices are not safe to use, in order to protect people's health and wellbeing.

Inspector's evidence

The NHS Trust's homecare team decided which people were suitable for the homecare service and told them who their homecare provider (pharmacy) would be. The trust then provided information about the person to the pharmacy, along with the person's first prescription. All prescriptions from trusts were sent to the pharmacy by post. When the pharmacy received the information about a new patient, the CST created a patient record and then phoned the person to explain how the service would be provided. The CST had access to a translator service for people who did not have English as a first language. New patients were also sent a welcome pack which included information about the pharmacy and the services it offered. The pack was currently only available in English, which meant some people may have difficulty understanding it. When people needed to, they could contact the pharmacy by phone or email.

The pharmacy ordered repeat prescriptions for people. The CST sent an email to the NHS trust 6 weeks before a prescription was due. And then sent a chaser every two weeks. If the pharmacy still had not received the prescription two weeks before the prescription was due, then the CST contacted the hospital care team at the trust to make them aware that a prescription had not been received and to pass responsibility to the hospital team to decide if a prescription was required. All third requests were reported to the homecare account managers so they could discuss any issues with individual hospitals. If a patient called the pharmacy after a third request the CST would contact the hospital urgently to follow this up. All calls and contacts were recorded on the individual patient's record. But overall, the number of late prescriptions was small. Some, but not all people had a buffer of medicines in case there were any delays in the system. This was decided by the NHS trust and was therapy dependent. As an alternative to buffer stock, some trusts provided repeat prescriptions in advance of patients next due dates. The deputy superintendent said that there were a small number of delays in patients getting their medicines when patients did not have buffer medicines, or the trust had not provided the next repeat prescription in sufficient time there have been instances of subsequent delays to patients.

Most prescriptions were repeat prescriptions which authorised the pharmacy to make several supplies at set intervals. When prescriptions were received by the pharmacy they were inputted onto the electronic system by the CST. A pharmacy technician then completed a check to make sure that it was legally compliant. A pharmacist then clinically screened the prescription. The CST then contacted the patient to arrange a delivery. The computer system allowed the pharmacists to see previous prescriptions for that person, and records of interventions or queries, to support their clinical check. The pharmacists did not have access to the person's hospital records, so relied on the checks made by the Trusts. All oncology prescriptions received by the pharmacy had been clinically screened by a pharmacist at the hospital. But not all other prescriptions had received this type of check performed by the referring hospital. Which could mean some clinical concerns could potentially be missed. Any missing information or queries relating to the prescriptions, such as unusual doses or wrong

formulations, was recorded on the person's medical records and the trusts would be contacted for further clarification. Pharmacy team members expected a response from the trust within a maximum of five days. They would send a chaser on day three and day five. If the patient had less than 10 days of medicines left, this would be highlighted as urgent, and the trust would be chased on the same day if no reply had been received. Additional chaser emails were sent if the patient contacted them. The deputy superintendent said that delays in receiving information led to a small number of patients missing doses.

The pharmacy's workload was organised by the delivery dates, and this was tracked to make sure it was completed on time. Oncology prescriptions were delivered the day after they were received. The pharmacy used an electronic dispensing audit trail to identify who had done each task. In addition, they scanned the prescription to release it to the next stage of the process and this was recorded on the person's PMR. Trays were used to keep medicines and prescriptions for different people separate to reduce the risk of error. When medicines had been dispensed, they were placed in a sealed secure box and labelled for delivery.

Most of the medicines were delivered by one courier service. The courier was regulated by the MHRA and had temperature-controlled vans to provide appropriate conditions for all medicines including those that required cold storage. The courier used vehicles fitted with real time tracking so the pharmacy could monitor them. The pharmacy kept records of any failed deliveries. Most failed deliveries were rescheduled with the possibility of a next day delivery. If necessary, the CST tried to contact the person three times to arrange a re-delivery and if there was no response, they sent the person a card and contacted the relevant trust to make sure that the person still required the medicine. Having carried out a risk assessment, the superintendent had decided that medicines returned by the main courier would be of the same quality as if they had remained in the pharmacy and were still safe to use.

Medicines were stored on shelves in their original containers. The pharmacy team had a process for date checking medicines. All medicine expiry dates were captured electronically when they were received and a monthly report highlighted medicines with less than 12 months, 6 months, 3 months and 1 month's expiry. At this point stock was removed from the shelves. In addition, the pharmacy team also date checked all medicines on the shelves on a monthly basis. A check of a small number of medicines did not find any that were out of date. A record of invoices showed that medicines were obtained from licensed wholesalers. The deputy superintendent said that they had a dedicated recall notification team who received MHRA medicine recalls. Their CRM system recorded all medicine batch numbers supplied to each patient so they could complete patient specific recalls when required. Records of all recalls and actions were maintained.

The pharmacy had a tracker so that they knew for the next few months the amount of stock medicines they would require. There were systems in place to forecast future stock orders, which helped to ensure medicines were ordered well in advance. The pharmacy had not experienced many stock shortages. NHS trusts set out the specific medicines required in the SLA which meant that if there were issues relating to long-term shortages, changes could not be made without the trust's approval, so the trusts had to be contacted to prescribe alternative medicines. This created a significant amount of additional work for the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

Inspector's evidence

The pharmacy had appropriate equipment for the services it provided. The pharmacy had up-to-date reference sources. Records showed that the fridge was in good working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy's portable electronic appliances appeared to be in good working order.

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.