General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Polar Speed Distribution Ltd, U P S S C S, Birch Coppice Business Park, Danny Morson Way, Dordon, Warwickshire, B78 1SE

Pharmacy reference: 9010674

Type of pharmacy: Closed

Date of inspection: 24/06/2024

Pharmacy context

The pharmacy provides a homecare medicines service which involves delivering ongoing medicines 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. 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 carries out regular audits and risk assessments to identify the risks associated with its services, then takes action to help manage them. Members of the pharmacy team follow written procedures to help them work effectively. They record things that go wrong so that they can learn from them. And they take steps to prevent their mistakes being repeated. And the pharmacy's systems protect people's privacy and confidentiality.

Inspector's evidence

The pharmacy had a business continuity plan and service level agreements (SLA) in place with various NHS trust across UK. Patients using the pharmacy's services were generally being treated for cardiovascular disease, cancer, immune system disorder and respiratory diseases.

The company had a comprehensive range of current standard operating procedures (SOPs) and policies in place to support its team members to work in a safe and effective manner. Team members from both the customer service team (CST) and the pharmacy team had signed the SOPs to confirm they had read and understood them. The SOPs were version controlled and they were reviewed every two years. Ad hoc adjustments were also made to the SOPs whenever appropriate, for example, following a significant incident.

A responsible pharmacist (RP) notice was on display and the RP records were appropriately maintained. Team members were able to explain their roles and responsibilities. And they knew which activities could not take place in the absence of a pharmacist. The pharmacy had current professional indemnity insurance in place.

The pharmacy had a risk register, which included a set of completed risk assessments. This was a live document which was reviewed every six months, and also as necessary in response to any major incidents. The pharmacy undertook regular audits to review the safety and efficiency of its services. Incidents and adverse events were recorded, including missed doses due to delivery failures or delays in receiving prescriptions. key Performance Indicator (KPI) data, trend analysis, call quality monitoring and analysis of audit results were discussed at monthly clinical governance meetings. Missed doses were also reported to the Trusts and pharmaceutical companies involved in the patient's treatment.

A recent audit had been carried out to look at the root causes of missed doses. This had found that most incidents had been caused by delays in receiving paper prescription from the relevant hospital which led to delays in delivering medicines to people. The pharmacy service itself had been responsible for very few of the missed doses or delays. The audit had included recommendations to help avoid missed doses in future, including bringing forward delivery schedules where possible, ensuring people had two weeks' worth of buffer medicines, and for the pharmacy to collect prescriptions for newly registered patients rather than waiting for the Trusts to post them. The pharmacy provided evidence to show that it had implemented the recommendations and that this appeared to have reduced the number of incidents.

The pharmacy team recorded mistakes that were spotted before a medicine left the pharmacy (near misses) using different codes for different type of errors. the director of pharmacy operations analysed

the records each month to help identify any emerging trends. A monthly report was compiled, and learnings were shared with team members. Team members also held a weekly meeting to discuss near misses and made suggestions on how to prevent similar events from happening again. If any errors had reached the patient, a full root cause analysis was undertaken and this was discussed during the monthly clinical governance meetings to decide whether any further action needed to be taken.

When patients first started using the pharmacy, they were sent a welcome pack, which included details of its complaints procedure. This information was also available on the pharmacy's website. People could also complain via the NHS Trust. The SI had an oversight of all complaints but they were mainly investigated by the director of pharmacy operations. The pharmacy team described things that had been done in response to complaints, to improve the service. For example, there had been some recent complaints about people having difficulty getting in touch with the pharmacy and phone calls being cut off. As a result, additional team members had been recruited in the CST and shift patterns had been reorganised to accommodate busier calling times.

The pharmacy held regular meeting with the relevant NHS Trusts and these were attended by the senior leadership from the company, including the superintendent pharmacist (SI) and the director of pharmacy operations. The meetings were used to discuss any problems with the quality of the service, including complaints, KPIs, errors in repeat prescriptions, delays in issuing prescriptions, prescriptions not being received as requested, long wait times on calls, and delays in responding to emails. The meetings then agreed actions to be taken to resolve any issues. For example, the pharmacy had identified that there were sometimes in delays in receiving the first prescriptions for new patients. So it was agreed that, where possible, the courier company would collect these prescriptions from the Trust to help speed up the registration process.

The company had acknowledged that recent staff losses had put pressure on the pharmacy team, which had impacted on the service it provided. But this had been addressed by recruiting pharmacists and support staff and appointing a pharmacy operations manager to help drive improvements. And to improve communication between the CST and the pharmacy team. There were also plans to open another pharmacy soon to increase capacity.

The Pharmacy’s IT systems were password protected and it was registered with the Information Commissioner's Office (ICO).
Confidential waste was appropriately managed. All team members had completed mandatory Data Protection Regulation training and this was revisited annually. The CST team always obtained consent from people before details about their therapy could be shared with the pharmaceutical companies. And anyone who contacted the CST team had to confirm their identity by answering date of birth and security questions, before any confidential information would be discussed.

Pharmacy team members had completed safeguarding training relevant to their roles and responsibilities. They were able to explain how they could recognise signs of concerns, and they knew how to deal with them and who to report to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to deliver its services safely and effectively. Team members have the training they need for the tasks they undertake. And they are supported with on-going training to keep their skills and knowledge up to date. and they can provide feedback and raise concerns with senior leadership to help improve pharmacy's services.

Inspector's evidence

Two separate teams were responsible for delivering the homecare service - the pharmacy team and the CST. The newly recruited team members were required to complete a robust induction plan, including a health and safety checklist and role-based induction to cover core duties. They were assigned a mentor and they were required to be signed off against a competency framework.

The pharmacy team consisted of three regular pharmacists, two pharmacy technicians who worked as accuracy checkers (ACT), five dispensing assistants and one person responsible for picking stock. One of the ACT was also the team leader and reported to the operations manager. All team members had completed accredited courses for their roles and their training certificates were available. The team member responsible for picking stock had been enrolled onto an appropriate training course but had not yet started the training. However, they had some relevant experience from a previous employment. Team members were seen to be working efficiently in their designated workstations and supporting each other. They confirmed that they were up to date with the workload.

The CST team consisted of sixteen team members and it was based in a separate room next to the dispensary. It was responsible for dealing with queries, setting up and registering new patients, contacting people to arrange deliveries, and making sure people had enough buffer stock of their medicines to mitigate against any delays with supplies. When necessary, the team would bring forward delivery schedules to ensure people always had at least two week's worth of buffer doses.

The pharmacy operations manager was responsible for monitoring the performance of both the CST and the pharmacy team, which helped to ensure good communication between the teams. Both teams had regular meetings and 'huddles' to discuss any incidents or near misses that occurred. Dropped-off calls and call waiting times were monitored. Audits showed that call waiting times were generally no more than a minute. The CST team responded to the sudden increase in inbound calls by opening more telephone lines and drafting in staff from other teams who may be involved in administrative tasks. The SI said that the senior leadership team listened to approximately 300 calls each month to monitor the quality of conversations. Feedback was routinely given to the CST team and mentoring was provided to team members if deemed necessary.

The pharmacy had contingency arrangements to manage planned and unplanned absences by employing locums. They used a specific locum agency who provided staff with experience in homecare services. Block bookings were made to cover annual leave and long-term sickness. Team members were flexible and changed their shift patterns to accommodate any increase in workload or queries.

The pharmacy had a whistle blowing policy and when asked all team members were aware of it. Team members communicated with each other verbally, via emails and during weekly meetings. The RP said

that they were able to give feedback about the pharmacy's internal processes both formally and informally and felt well supported by the SI, who was approachable and encouraged open and honest culture in the pharmacy. The pharmacy operations director visited the site regularly and the team could speak to him if they had any concerns.

Team members were well supported with on-going training to help keep their skills and knowledge current. They received in-house training. And a significant amount of training was also provided by the pharmaceutical companies and the NHS Trusts. They were given time during working hours to complete their training. The pharmacy had records of all completed training and these were available for inspection.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are suitable for the services provided. And they are secured against unauthorised access.

Inspector's evidence

The premises were in a large industrial unit and they were not accessible to the public. People visiting the site were required to sign in at the reception and access to each part of the building was controlled by key cards. The CST team worked in a separate room next to the pharmacy team.

The dispensary was of an appropriate size for the workload. It was clean and tidy, and there was enough space to store medicines and undertake dispensing activities safely. The ambient temperatures were continually monitored and temperature probes were placed throughout the building. Team members had access to hygiene facilities and a staff room.

The pharmacy website included information about its services and contact details. It also included details of the senior management and the SI’s name and registration number.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and effectively to ensure people receive their medicines on time. The pharmacy team communicates well with people so that they get the care and support they need to take their medicines safely. The pharmacy obtains its medicines from reputable sources and stores them correctly. And it carries out appropriate checks to make sure people get medicines and medical devices that are fit for purpose.

Inspector's evidence

People could contact the pharmacy by phone or email. The CST team was the initial point of contact and would then direct to other teams as and when it was necessary. All patients had to be registered with the pharmacy before they could use its services. The NHS Trust's homecare team allocated people to the pharmacy by initially completing a registration form which included signed consent from the person agreeing to use the service.

Most prescriptions sent to the pharmacy had been clinically screened by the hospital's clinical team. The RP explained that prescriptions received from the Trust were marked to confirm this had happened but said a few were received that had not been marked. When this happened, the RP would compare with prescriptions from previous months and use his professional judgement to decide whether to supply or whether to telephone the Trust to confirm that the prescriptions had been clinically screened. These instances were a potential cause of delay and so were logged and discussed during meetings with the Trusts. The Trusts also sometime needed to be contacted to answer any other queries or clarify any missing information. Pharmacy team members said that the Trusts normally responded to queries within 24 to 48 hours, but if no response was received by then, a chaser email was sent. These interventions were recorded on the person's medical records.

Occasionally the Trusts made urgent requests for new patients. In these instances, the pharmacy dispensed medicines against scanned copies of the registration forms and prescriptions. The pharmacy kept an audit trail to ensure the scanned copies were reconciled with the physical paper copies of the prescriptions when they were received.

When a new patient's application was received, the CST created a patient record and scanned across the registration form and prescriptions into the person's medical records. The CST then made a welcome call to the person to explain how the service worked and confirm all the relevant details including the delivery schedule and the person's preference as to how they wished to be contacted. The pharmacy also posted a welcome pack which included information about the pharmacy and the services it offered.

The pharmacy team kept track of repeat prescriptions due to be ordered and generated a list for the CST team to use. The CST team was responsible for ordering the prescriptions from the relevant Trusts by email. They were normally ordered four to six weeks before the medicines were needed, and the SLA was for the prescriptions to be received by the pharmacy five days in advance. The pharmacy team reported that most Trusts sent the prescriptions well in advance so there were not normally any problems with the prescriptions not being received on time.

The pharmacy's workload was generally organised by the delivery dates and the operations manger viewed the upcoming workload due to be completed. The workload had remained stable and generally predictable. Prescriptions received by the pharmacy were clinically screened by pharmacists to ensure correct quantities and dosage had been prescribed. The pharmacists had access to patient medication records to assist with the clinical checks. However, the pharmacy team did not have access to the person's hospital records. So relied on the checks made by the Trusts. The prescriptions would then be assembled using the physical copy of the prescription and sent for a final accuracy check by a pharmacist or an ACT. Dispensed medicines were then placed in a sealed secure box and labelled for delivery.

Medicines were delivered by a courier service. The courier used vehicles fitted with real time tracking so the pharmacy could monitor them. The delivery vehicles had controlled storage conditions to keep medicines at the correct temperature during transit. The pharmacy kept records of any failed deliveries and the reasons why they had happened. So that there was an audit trail that could be used to address any subsequent complaints or queries. The SI had a good oversight of the delivery service and the logistics overall. Failed deliveries were returned to the local transport depot and a re-delivery was attempted for the next day. Patients were contacted to let them know what had happened and to confirm they would be available to receive the next delivery.

The pharmacy had a separate team responsible for procuring stock. Stock medicines were obtained directly from the contracted pharmaceutical companies. Most medicines the pharmacy supplied were specialised and could only be supplied by designated pharmacies. There were systems in place to forecast future stock orders, which helped ensure medicines were ordered well in advance. The pharmacy had not experienced many stock shortages. Any issues relating to long-term shortages were picked up by the procurement team and the trusts were contacted to prescribe alternative medicines. Safety alerts and recalls were received from various organisations including the MHRA, NHS trusts and pharmaceutical companies. The records seen during the inspection showed that team members actioned these in a timely manner. Batch numbers were recorded on prescriptions to ensure people could be contacted in the event of any recalls or safety issues. The pharmacy vigilance team recorded and reported any adverse events or safety issues relating to the medicines back to the pharmaceutical companies.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the equipment and facilities it requires to provide its services safely and effectively. It appropriately maintains its equipment and it has suitable arrangements to ensure its equipment and facilities remain fit for purpose.

Inspector's evidence

Team members had access to the internet and a wide range of up-to-date reference sources. People's confidential information on the pharmacy's computer system was password protected. A good number of computer terminals were available so that more team members can take calls when the volume increased. Team members had access to headsets to allow conversation to take place in private. All electrical equipment appeared to be in good working order. The pharmacy's IT system was serviced and maintained by an external company and help desk support was available for any technical difficulties.

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.