General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmaxo Pharmacy Services Ltd, 1 Corsham Science Park, Park Lane, Corsham, Wiltshire, SN13 9FU

Pharmacy reference: 9011213

Type of pharmacy: Internet / distance selling

Date of inspection: 18/07/2024

Pharmacy context

The pharmacy provides a homecare medicines service which involves delivering ongoing medicine supplies direct to people's homes. The majority 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 a purpose-built industrial unit and the premises is not open to the public. 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

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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 effectively manages the risks associated with its services to make sure people receive appropriate care. It uses regular audits and risk assessments to review its services and improve the way the pharmacy operates. Members of the pharmacy team follow written procedures to help them work effectively. They record their mistakes so that they can learn from them. And they make changes to stop the same sort of mistakes from happening again. There are clear safeguarding procedures in place and the team understands its responsibilities to keep vulnerable people safe.

Inspector's evidence

The pharmacy had master service agreements in place with a number of NHS Trusts to provide homecare services to patients in the community. The dispensing team was part of a much larger team which included departments such as quality management, business development, finance, human resources, administration, and a customer services team.

Pharmacy incidents, including dispensing errors and complaints, were recorded on the computer system and investigated. Dispensing incidents were recorded electronically, and this included a root cause analysis as part of the error investigation. Weekly clinical governance meetings were held by the pharmacy team to look for trends as well as any changes that needed to be made to reduce the risk of errors. The pharmacy team explained that a change in the size of ampoule of water for injections had led to some people assuming it was sodium chloride. In response, the pharmacy team had taken steps to highlight the difference between the two. The clinical governance meeting was also used to discuss any feedback or patient complaints as part of a service quality management system.

A barcode scanning system was in use to reduce the risk of selection errors and cameras were in use so that people could identify exactly what had happened during the dispensing process that led to a mistake. A labelling system was in use that capitalised specific letters in the names of medicines with the intention that this would reduce the risk of selection errors.

The pharmacy team carried out a variety of risk assessments. Risk assessments started when the company was considering a new service or exiting a service. The pharmacy team provided evidence of a robust and detailed risk assessment that had been carried out due to the pharmacy discontinuing a variety of services. The superintendent pharmacist explained that these were business decisions based on the level of demand of a service. Patient impact assessments had been carried out for the services that were being discontuined, and these considered the risk to the patient and possible mitigations that could be put in place to limit these risks. For example, the pharmacy had mutually agreed the time that they would exit a master service agreement so that the NHS Trust involved could re-direct the patient to another provider.

The pharmacy team regularly completed audits of missed or delayed doses to people’s medication. They reviewed all missed doses monthly with the information available. This includes capturing of any missed doses that were not raised as a complaint. This data was reviewed and shared with NHS Trusts. The pharmacy team and NHS Trusts could then use the data to identify trends and themes of missed doses, with a view to developing strategies to reduce the risk of these. This could be by offering staff further advice or training, for example. The pharmacy team gave an example of an audit into the

compliance of the dosing of complex multi-day chemotherapy cycles. They explained that doses had been missed because nurses found it difficult to navigate the electronic system used to view, record and administor doses of medication. A training package was introduced which was designed to help the nurses use this system effectively. Eight weeks later, a second audit was carried out to assess the effectiveness of the recommendations of the first audit, and it demonstrated that doses were less likely to be delayed.

There was an established workflow in the pharmacy where labelling, dispensing, and checking activities were carried out at dedicated areas of the work benches. The team used containers to hold dispensed medicines to prevent mixing up different prescriptions. Standard operating procedures (SOPs) were in place for the services provided and were regularly updated. Records were kept to indicate that each member of the pharmacy team had read and signed the SOPs. When questioned, members of the pharmacy team were able to explain their roles and responsibilities. There was a complaints procedure in place and members of the pharmacy team understood the processes they should follow if they received a complaint. People were asked to complete satisfaction forms after visits to their homes by members of the nursing team. People could also submit feedback via telephone or via the website and this was clearly signposted in the patient information leaflet. The pharmacy team described a situation where people had complained about the service as they could not easily contact the pharmacy by telephone. This was because the service levels had outgrown the older telephone technology that the organisation was using. In response, a new telephone technology system had been implemented, and a tracking system established so the team could easily monitor calls that were waiting. This had led to a significant reduction in complaints from people.

A current certificate of public liability and indemnity insurance was available.

A responsible pharmacist (RP) record was kept, and the RP notice was prominently displayed. Appropriate prescription records were kept electronically. The pharmacy did not have any controlled drugs (CDs) at the time of the inspection.

Confidential waste was separated from general waste and disposed of by the pharmacy appropriately. An information governance policy (IG) was in place and the pharmacy team were required to complete this as part of their training. There was a safeguarding policy in place. Members of the team were aware of signs to look out for that may indicate safeguarding concerns in vulnerable adults. They could locate contact details to raise safeguarding concerns depending on which area the person needing support was in. All staff had safeguarding training to a level that was dependant on their role.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained and qualified team members to manage the workload and the services that it provides. It considers staffing levels as part of future workload planning and completes recruitment and training before any additional work is undertaken. The team members work well together in a supportive environment, and they are encouraged and empowered to make suggestions.

Inspector's evidence

The pharmacy team comprised of six pharmacists, four pharmacy technicians, one of whom was employed as an accuracy checker, nine dispensing assistants and three pharmacy support assistants. All members of the team had completed appropriate training for their roles. The dispensary team was supported by various other people and departments which meant that there were many people based at the premises. Patient service advisors were employed to manage activities such as liaising with patients and managing prescription queries. A policy was in place to ensure that more complex queries were escalated to a pharmacist or pharmacy technician. The pharmacy team always had a minimum of one pharmacist working directly with the patient service team to ensure that queries were dealt with in a timely manner.

The recruitment of staff was carefully managed to keep up with growth of the business. Dispensary managers carried out regular reviews of the staffing levels and skill mix in the pharmacy. They ensured that members of the team were trained across different areas of the business to provide flexibility. The superintendent pharmacist gave an example of a period where the patient service advisor team had been short staffed, which meant people were waiting longer to have their queries answered. In response, a greater proportion of the team were appropriately customer service trained so that they were able to be drafted in to help the team during busy periods.

Team members had protected learning time and regular performance reviews with their managers. Managers reviewed the performance of their team members in different ways, dependent on their role. For example, the patient support team had some of their telephone calls reviewed and they were given the opportunity for reflective feedback. A bespoke training module for the customer service skills on the telephone was being used specifically for the patient support team. Members of the team explained that this had helped them deal with challenging situations over the phone.

A pharmacy quality team was located in the shared office area and provided training, coaching and mentoring. This included regular engagement with the teams following any complaints or incidents to ensure that there was full understanding of what had happened and how to resolve any issues. All staff completed bespoke training packages developed by an in-house training team and this covered knowledge of the regulated activity, managing complaints and incidents, the safeguarding of vulnerable adults and operational task training. The pharmacy team were also required to complete mandatory training, such as fire safety, safeguarding and pharmacovigilance. Training modules were uploaded onto an online platform and tracked to ensure that they were completed in the required timeframe. The pharmacy team were regularly asked for feedback about their work. Pharmacists had provided feedback that they lacked knowledge of some oncology treatments, so in response they had been provided with external e-learning in conjunction with the British Oncology Pharmacy Association.

The pharmacy team all had their own MS Teams account to communicate with other people in the organisation. A variety of employee support policies were in place and the pharmacy team felt that they were able to raise concerns if necessary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe and appropriate environment for the provision of its services. The premises is secure and protected from unauthorised access.

Inspector's evidence

The pharmacy was located on an industrial estate and was not open to the public. The pharmacy premises was secured from unauthorised access. It was spacious with a clear workflow throughout, professional in appearance, and was clean and well maintained. The building had two levels and the dispensary was on the ground floor. On the second level, there was a meeting room, a break-out area and a large office area where administrative work was carried out including stock management, quality control, staff training, finance, prescription receipt, screening, and delivery. The pharmacy website included contact information for the pharmacy.

The ambient temperature and lighting throughout the pharmacy was appropriate for the delivery of pharmaceutical services. The pharmacy was well ventilated. There was sufficient workbench space for the team to complete their work. There were hand washing facilities available on-site. There was also a staffing area which contained appropriate toilet facilities. The pharmacy was locked when closed and was fitted with an alarm system to prevent unauthorised access. There was also closed-circuit television monitoring on-site and in the pharmacy. Access to the building and different parts of it were securely controlled by key cards.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible, effectively managed and delivered safely. The pharmacy obtains, stores, and manages medicines safely and ensures that all of the medicines it supplies are fit for purpose. The pharmacy team takes appropriate action where a medicine is not fit for purpose. And members of the pharmacy team give people the support and information they need to use their medicines safely.

Inspector's evidence

As a specialist home healthcare pharmacy, the pharmacy had contracts with various NHS Trusts to supply people directly with their medicines and ancillary items. Several members of the team could speak different languages, including Polish, Portuguese and Russian. And the pharmacy had access to translation services if necessary.

Patients would be referred to the pharmacy from a variety of different NHS Trusts. NHS Trusts would send a prescription electronically for each new patient and then the pharmacy team would start the dispensing process. Each new patient would receive a welcome pack. This included a patient information leaflet that outlined how the homecare service would be provided and how the home nursing assistance worked. Each patient would also receive a welcome call from a trained patient services team member to check their understanding of the service. Pharmacists were available to speak to people about medical queries if necessary. The pharmacy team gave examples of when they had spoken to people on the telephone to discuss topics such as administration technique. Notes were kept of these conversations on the patient's medical record.

Prescribing was done with electronic instalment prescriptions, which authorised the pharmacy to make a specific number of supplies. These were then scanned into the dispensing system by the phamacy team using barcode technology, and medicines were dispensed using individual barcodes for each item. Audit trails were kept to show what part each team membver had completed in the process.

When new prescriptions needed to be ordered, emails were sent to the NHS Trusts to ask them to contact the individual prescribers within their Trust and start the process for a new prescription to be issued. Chasers were sent at regular intervals if a prescription was not received. It was the Trusts responsibility to ensure the pharmacy received prescriptions on time. The pharmacy team explained that they had previously escalated concerns to NHS Trusts who they identified had not been supplying prescriptions on time. The NHS Trusts would then have meetings with the individual teams that had not been supplying the prescriptions in a timely manner. This had meant that there had been fewer delays when receiving prescriptions.

The clinical screening of each prescription was completed by clinical teams at the Trusts before the prescriptions were sent to the pharmacy. The pharmacy team then carried out the supply of the medication only. Members of the team had access to the people's diagnosis and allergy status. Prescriptions were sent electronically to the pharmacy and the pharmacy team followed a clear workflow to dispense and check each prescription. There were pharmacists in the dispensary who could escalate and triage any issues or queries at the dispensing stage and offer advice if necessary.

The pharmacy used medical couriers for most of its deliveries. There were other providers available, such as the Royal Mail and DPD, but these were only used on a contingency basis. The pharmacy also had access to a same-day delivery contingency logistics provider. The courier used vehicles equipped with robust, temperature-controlled compartments and the service had been audited by the pharmacy team to ensure that they were delivering medicines in a safe and effective manner. A text message system was then set up where the pharmacy team advised people of a two-hour window in which their medicines would be delivered. All medicines were delivered using special delivery and had to be signed for on receipt.

The pharmacy team worked with the logistics providers to ensure that medicines were supplied safely to people. This included a risk-based assessment, quality technical agreement and, where deemed appropriate, a full supplier audit. Ongoing performance was monitored and reported to the Trusts.

Many of the medicines the pharmacy supplied were specialist and could not be obtained from the usual pharmacy wholesalers. So, the pharmacy had contracts with manufacturers and obtained medicines directly from them. The fridge temperatures were recorded using probes and were within the two to eight degrees Celsius range. There was sufficient fridge space to store medicines requiring cold storage. If the temperature of any of the fridge went out of range, the pharmacy team were alerted to this. Date checking was carried out on an on-going basis using an electronic barcode system.

The pharmacy also had a sister company, Bath ASU, which manufactured and supplied medicines to the pharmacy which would then be disepensed to patients. The pharmacy electronically recorded which batch numbers had been supplied to which patient so it could directly contact people in the event of a product recall. MHRA drug alerts and recalls came to the pharmacy electronically and the pharmacist explained that these were actioned appropriately. Records were kept verifying this. These were audited every month to ensure all alerts had been received and actioned.

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. It appropriately maintains its equipment and it has suitable service arrangements to help make sure its equipment remains fit for purpose.

Inspector's evidence

The group that owns the pharmacy had access to maintenance, IT and engineering support teams. IT issues were usually solved in-house. The team reported that all calls for assistance had been dealt with promptly. The pharmacy has a patient medical record (PMR) system which was secure and validated. It was possible to identify anyone who accessed the system to view a patient record or dispense an item. IT and computer systems were access-controlled, password protected and backed up.

There was a business continuity plan which meant that the pharmacy team could plan and react to adverse events and situations. The pharmacy team described what they would do if they had a total systems failure. There was a shared level of access to the facilities and technology of the sister company Bath ASU.

The pharmacy team had access to a range of up-to-date reference sources, including the British National Formulary. Internet access was available. Patient records were stored electronically and there were enough computer terminals to ensure that the pharmacy team could complete their work in a timely manner.

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.