

Registered pharmacy inspection report

Pharmacy Name: HealthNet Homecare, Unit 1 & 2, Orbit Business Park, Alfred Eley Close, Swadlincote, Derbyshire, DE11 0WU

Pharmacy reference: 9011236

Type of pharmacy: Homecare Medicines Service

Date of inspection: 20/06/2024

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 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 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 service level 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, new services development, business development, finance, I.T., human resources, client services, warehousing, logistics and a customer services team.

The different teams were linked using bespoke computer systems to manage the end-to-end processes and governance. The systems had various functions which included sending prescription requests to NHS Trusts, storing scanned copies of original prescriptions, electronic audit trails for each prescription, details of telephone conversations, details about home deliveries, workload planning information and invoicing. Staff signed in individually so that every activity was auditable. The system provided reports of actions that were used by the management team to monitor performance. The computer systems were regularly reviewed and updated.

The management teams carried out a wide range of risk assessments. Risk assessments started when the company was considering tendering for a new service or providing a new treatment, and then continued throughout its development. The company had a New Services Implementation Manager who managed the process. The risk assessments were recorded and used by relevant internal stakeholders, such as the superintendent pharmacist (SI), the director of quality and the operations managers. Risk assessments were carried out as a team activity to ensure all of the people responsible for the implementation of the service were involved in them. Action plans were created to address specific risks that were identified, and automated reminders were used to ensure the actions were completed in the agreed time scales. Different tasks were allocated to different teams and the impact and requirements for the entire company were included. The pharmacy had a pharmacovigilance (PV) department which gathered information about the medicines that it supplied and their effects on the patients. This included information about side effects or the effect if a dose was missed. Team members used PV forms to record any issues that came to light, and they completed annual PV training.

The pharmacy had a range of standard operating procedures (SOPs) which covered the services it provided, and they were regularly reviewed by the SI. The SOPs were held electronically on the computer system and an automatic alert was generated when a SOP was due for review. Each SOP had a number of approvers who had expertise of that particular part of the pharmacy's operation. Electronic records were kept to show that team members had completed training on the SOPs relevant to their roles.

Pharmacy incidents, including dispensing errors and complaints, were recorded on the computer system and investigated. If a significant or serious incident was reported, the pharmacy informed the NHS Trust by telephone and followed up by email. Depending on the nature of the incident, some investigations were led by the Trust, and others were led by the pharmacy. A recent record related to a dispensing incident involving methotrexate. A root cause analysis identified that the way that the electronic prescriptions had been uploaded to the system had been a contributing factor. To help avoid similar mistakes in the future, the pharmacy had updated the way prescriptions were uploaded to the system and annotated to show when there was an increasing or decreasing dose regimen.

The dispensary management team monitored accuracy throughout the dispensing process and maintained detailed records which they reviewed weekly. Errors at this stage in the process were known as near misses. Team members were encouraged to inform the person that had made the mistake and the team reported that there was an open and honest culture towards errors. Each dispensary manager had informal weekly one-to-one meetings with their team members and part of their discussion was about what could be done to improve their dispensing accuracy. The pharmacy used an automated labelling system at the assembly stage of the dispensing process; therefore, most incidents related to how the team had inputted information into the system. There was some manual dispensing, however, this was done by exception. Through recording near misses, the team had identified that there was a risk in selecting the wrong type of injection device from the computer system, so they had discussed this and decided to add in a note to the prescription audit log to show that they had specifically checked the injection device type when inputting the data.

The pharmacy could be contacted by telephone and email. Over the past few years, the team had noticed an increase in the number of people choosing to email their query and people also chose to use the self-service options for ordering their next supply. The pharmacy had a patient portal on the website and a smartphone application (app) to allow people to do this. There was a clinician portal which NHS Trusts used for various tasks. The team managers reviewed the telephone waiting times and the number of emails against key performance indicators throughout the day and made changes to the allocated tasks when required. Incoming calls could be directed to just one of the company's pharmacies as part of the business continuity plan, and the teams had access to patient information from both pharmacies so that they did not need to redirect many calls. The complaints process was explained on the pharmacy's website and in the welcome guide. The SI and operations lead monitored complaints and gave examples of positive improvements that had been made to address patterns. For example, the delivery drivers were required to telephone the logistics team whilst they were still at an address if the person was not home. The logistics team telephoned the person to discuss the delivery rather than the driver simply not making the delivery. This allowed the person to provide alternate delivery instructions, for example, deliver to a neighbour, or another person at the same address could sign for the deliver on their behalf.

A current certificate of professional indemnity insurance was displayed. The responsible pharmacist (RP) notice was prominently displayed at the entrance to the premises. The RP log was recorded in accordance with legislation. One controlled drug was in stock, and a weekly balance audit took place. The CD register was electronic and complied with requirements. Fridge and ambient temperature records were maintained electronically.

All computers were password protected and staff members had individual sign in details which they did not share. Confidential waste was destroyed securely. The company's privacy policy was on the website. The team were aware of data protection when sending emails and removed information that they did not think was relevant. The customer services team confirmed that they were talking to the right person on the telephone before discussing medication details. Access to the premises was

controlled and visitors were required to sign in and wear a visitor's lanyard. Visitors were asked to show their ID if they were not known to the team. Staff wore their ID on a lanyard, and this was used to control access to certain parts of the premises for security purposes.

There were named safeguarding leads who had completed advanced training. Other team members completed different levels of safeguarding training dependent on their roles. The home delivery team employed by the logistics company were also required to complete safeguarding training. The patient support team understood their role in safeguarding vulnerable people and gave multiple examples of safeguarding concerns that they had identified and acted upon. For example, a patient said that a family member was taking money from them and not caring for them as needed. This was reported to the internal safeguarding lead and then reported to the adult safeguarding team where the patient lived. There was support available for team members following them raising safeguarding concerns.

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 dispensary team comprised of four pharmacists, 10 pharmacy technicians, nine of whom were trained as accuracy checkers (ACPT), 15 trained dispensing assistants, two of whom were trained as accuracy checkers, four general assistants and seven prescription management administrators. One of the ACPTs worked as the site manager and three of the ACPTs were assistant dispensary managers. The dispensary team was supported by various other people and departments which meant that there were lots of people based at the premises.

The assistant dispensary managers were responsible for the day-to-day operation of the dispensing service, which included organising the workload and allocating the team members their various tasks. The team members were trained to undertake the various stages of the dispensing process, rather than just one part of it. They explained how this had helped provide contingency cover for sickness and to ease any bottlenecks. For example, pharmacy team members were trained to carry out the manual dispensing process and the automated dispensing process so they could be allocated either of the tasks to cover for sickness or holidays. The pharmacy business had grown by taking on new business from NHS Trusts. The growth had been carefully planned and managed, so that the pharmacy had been able to recruit team members and train the team in advance of making any changes. Annual leave was booked in advance through the HR intranet system, and this was authorised by the pharmacy management team.

Pharmacy team members had protected learning time and regular one-to-ones with their manager. 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 training module for developing communication skills on the telephone had been created specifically for the patient support team.

Members of the pharmacy team were required to complete mandatory training, such as fire safety, safeguarding and pharmacovigilance. This was uploaded onto an online platform, and completion rates were tracked to ensure they were done promptly. Team members felt that there was an open culture, and they were encouraged to speak out if they had any worries or concerns. A team member described how constructive feedback had been given to him to support his development. Team members could request a review or update to SOPs or policies if they identified that the process had changed. This was reviewed by the quality team, and it was either acted upon, or the team would be reminded to follow the correct procedure. The company values were displayed and there was a clear mission statement.

Various employee support policies were in place. People wore different coloured lanyards so that they were recognisable in any additional roles such as being first aid trained, or mental health first aid

trained. There was a focus on women’s health and wellness and a defibrillator had been purchased.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and properly maintained. It is secure and safeguarded from unauthorised access. And it provides an appropriate environment for healthcare services.

Inspector's evidence

The pharmacy had a website which contained information about the company and other useful information for people using its services. The website contained details of the pharmacy such as, the premises address, the services offered and contact details. The pharmacy did not sell medicines through the website or offer any online prescribing services.

The pharmacy was smart in appearance and well maintained. The premises had been purpose built and intentionally designed to future-proof the business as there was ample space to expand. Any maintenance issues were reported to a central email address and dealt with by the on-site facilities manager. The pharmacy, offices and warehouse were clean and tidy. The premises had a set number of hours of contracted cleaning time each day and a deep clean was carried out at regular intervals. Routine pest control measures were in place and documented. Staff break and toilet facilities were available.

There was a large dispensary where manual dispensing tasks took place, and a second dispensary housed an automated assembly system. A separate room was used by the patient support team and for administrative tasks.

The building temperature was carefully monitored, and temperature probes were positioned throughout the premises, including the fridges. The temperature probes were linked to an electronic monitoring system and alerts were sent to key personnel if the temperature was out of the identified range for a set period.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy manages its services well and it supplies medicines safely. It continues to evolve and has introduced innovative projects to improve its efficiency and support patient safety. It gets its medicines from licensed suppliers, and it keeps them in good condition so that they are 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 with their medicines and ancillary items. The contracts specified which medicines would be supplied and there was a specific formulary of medicines that could be prescribed.

The pharmacy's website included links to the patient portal and to the clinician gateway which allowed patients and clinicians to access services. The website had an automated secure chat function that signposted people to the information that they required or advised them to contact the patient services team if they needed a personal response. The pharmacy also had a smartphone app that people could use to order their next delivery and carry out a number of tasks such as recording how much of their medicine they had left, choosing a date for their next delivery and selecting which ancillary items they required.

The pharmacy classed the NHS Trusts as their 'customers', and dispensed prescriptions to patients on behalf of the NHS Trusts. When a patient was first prescribed a medicine, the hospital explained how clinical healthcare services worked and that prescriptions would be dispensed and delivered by HealthNet Homecare. The hospital gained the patient's agreement and passed the details to the pharmacy together with the prescription. A new patient team based at the company's other pharmacy was responsible for adding the patients details to the system and communicating with the nursing team who then organised a nurse visit (if requested by the Trust). All new patients were sent a welcome guide which explained how the service worked. It contained information such as, the contact details for the patient support team, what to do if they experienced any side effects, the privacy notice, and the complaints procedure.

Most prescribing was by instalment prescriptions, which authorised the pharmacy to make several supplies. Each prescription had a unique reference which recorded how many supplies were permitted and how many had already been made. When a new prescription needed to be ordered, an automated prompt email was 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.

After the initial supply, the pharmacy telephoned patients to arrange further deliveries, unless they chose to use the website or smartphone app to order their own. People who used the website or app were prompted to log in and order their next delivery around two weeks before it was due. The system was configured so that the person could select the ancillary items from a list that was matched to their

prescription. This could range from a single item, such as a sharps bin, to a much longer list for some of the more complex therapies. The system also captured how much medicine the person had in their home (buffer stock). The person was given a choice of delivery options and could choose to have their prescription delivered to an alternate address if they preferred.

The company had a secure electronic prescription platform that Trusts could use to create and sign prescriptions quickly and efficiently. Some Trusts had chosen to adopt the electronic prescription platform, but most still submitted paper prescription forms. This meant delays could be caused by postal strikes and other postal delays, so these issues were included in the pharmacy's business continuity plan and risk assessments.

The electronic prescription platform was one of a number of initiatives that had been implemented to support the company's sustainability strategy. A carbon reduction plan was published on the website and a number of steps had been taken to reduce the carbon footprint. For example, the pharmacy premises had solar panels, the team used environmentally friendly cleaning products, and had appointed a sustainability champion. Delivery notes were sent electronically to save paper and a device recycling scheme was being trialled with one of the manufacturers.

The pharmacists carried out clinical screening of all prescriptions. There were different checks completed dependent on the prescription type. The computer system allowed the pharmacists to see previous prescriptions for that person, and records of interventions or queries to support the clinical check. The pharmacy did not have access to the patient's hospital or NHS notes but a healthcare professional at the NHS Trust performed a clinical screen of the prescription before it was sent to the pharmacy to review test results and other treatments. The pharmacy kept records of any prescriptions they received that had not been clinically screened by the Trust, and fed this back during their regular meetings, so the Trusts could use the information to improve compliance with the service level agreements. The pharmacists made interventions with the NHS Trusts as they felt necessary. They telephoned or emailed queries to the prescribers, and the interventions were recorded on the pharmacy's computer system.

Workload was organised by delivery date and the dispensary management team could view the upcoming work due to be completed. The team were allocated different tasks dependent on the workload for that day. As many of the prescriptions contained medicines that needed to be stored in the fridge, there were large walk-in fridges in the warehouse to store completed prescriptions that were awaiting delivery.

The automated labelling system process used barcode and QR code technology to track each step. This information linked to prescription items for individual patients. The system alerted team members if an intervention was required by a pharmacist or ACPT. A pharmacy professional then had to log-in to complete these interventions before the dispensing could proceed. The system also required an accuracy check by a pharmacist or ACPT on a proportion of the orders processed or on those placed into quarantine as a quality control.

The cold chain was validated regularly using temperature data loggers so that any temperature fluctuations within the dispensing and delivery process could be identified and addressed. A data logger was added to a dummy prescription basket which progressed through the dispensing process as a normal cold chain prescription would. This was then packaged and sent out using the logistics company and returned to the pharmacy where the results were analysed by the quality team.

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 pharmacy recorded which batch numbers had been supplied to which patient so it could directly contact people in the event of a product recall. The PV team recorded any reported side effect or issue, however minor, and these were reported back to the manufacturers to assist with safety monitoring. The pharmacists were available to speak to people about their medicines and gave examples of when they had spoken to people on the telephone to discuss queries about matters such as injection technique if a person had complained about their injection devices not working as expected. The pharmacy had a cascade system in place for patient level recalls, and the management team carried out a regular test to make sure the system worked.

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 pharmacy's automated system was serviced and maintained by the systems manufacturer, who conducted routine servicing on a regular basis. There was a service support desk available for technical difficulties when needed. The team reported that all calls for assistance had been dealt with promptly.

The pharmacy computers were password protected. It had a good supply of baskets fitted with sensors to support the high throughput of the assembly process. There was also a backup generator to maintain the service in the event of a power cut, and backup arrangements to maintain the internet connection. The backup generator was tested every week, and portable appliance testing was up to date.

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 terminals for the workload currently undertaken. Large computer screens were used to allow for several documents to be open and visible on the same screen.

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.