General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Personal Homecare Pharmacy, 9 -11 High View Close, Leicester, Leicestershire, LE4 9LJ

Pharmacy reference: 9012031

Type of pharmacy: Internet

Date of inspection: 31/07/2024

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 a semi-industrial unit and the premises is not open to the public. The Company is registered with the MHRA and holds a Wholesale Dealers Authorisation. The pharmacy also provides a fertility treatment service. 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 has systems in place to identify and manage the risks associated with its services. Its team members have defined roles and accountabilities. Its team members record things that go wrong, and they can give examples of action they have taken to improve the service they provide. But some learning opportunities may be missed.

Inspector's evidence

The pharmacy provided a homecare medicine service that involved supplying two specialist biosimilar medicines and fertility treatments. The biosimilar medicines could only be supplied by pharmacies approved by the pharmaceutical company that made the medicines. It had service levels agreements (SLA) in place with various NHS Trusts across the UK. The pharmacy did not provide nursing care but had close links to the nursing care provider who provided these services. The pharmacy also traded under the name Fertilty2u, fertility treatments were supplied for NHS clinics, private clinics in the UK and a small number of overseas clinics for UK based patients.

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. When asked, the team members in the CST could confidently explain their roles. A responsible pharmacist (RP) notice was on display and RP records were appropriately maintained. The private prescription record was maintained electronically and held all the required information.

The pharmacy had a business continuity plan in place. The pharmacy had completed risk assessments looking at key risks for both areas of the pharmacy service such as time to dispense medicines, missed deliveries and the impact of growth of the pharmacy. They constantly reviewed their KPI (key performance indicators) to make sure that they complied with their SLAs. The pharmacy checked annually that prescribers sending prescriptions from private fertility clinics were still registered with their regulatory body. And that UK clinics were registered with the Care Quality Commission. The pharmacy explained that the processes they had in place meant that they nearly always received prescriptions on time and delivered them on time to the patient. This meant that they had very few occasions where people missed a dose of their medicine, but missed doses were reviewed and reported to the NHS Trust. The CST room had a dashboard showing the number of calls waiting from people ringing the pharmacy, average and longest waiting times. If the numbers 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 two minutes.

The pharmacy had expanded in the last year taking on a number of new contracts with NHS Trusts. They carried out a risk assessment of each new service using a capacity planning tool to ensure that they had sufficient staff to provide the service safely. They were also using Artificial Intelligence (AI) to improve the efficiency of the service. For example, when a new person started the service the NHS Trust sent the pharmacy a registration form. The pharmacy was using AI to upload the information onto their system. This had released a substantial amount of time for their customer service team to carry out other tasks. The pharmacy was also building a new premises which would provide more space and

an improved layout.

Agreeing an SLA with an NHS trust usually took several months and when a trust started using the pharmacy usually only new patients rather than those who were already receiving a homecare service from another provider would be initially registered. This gave the pharmacy time to build capacity and relationships. People who were being switched from another medicine to the medicines being supplied by the pharmacy were then registered at a later date. The pharmacy had an increased number of missed doses in June 2024. They had identified the cause as being due to problems taking on a service for a new NHS Trust, and incorrect patient data provided by the trust. To avoid similar issues in the future, they had amended the process around the information they gathered from NHS Trusts during the onboarding process.

The pharmacy held regular performance meetings with the relevant NHS trusts to discuss any issues or problems with the service, KPIs were reviewed, and service development was discussed, for example it had been recently agreed to introduce face-to-face translators for when people received their initial injection training when required. The meetings were attended by the senior leadership from the company including superintendent pharmacist (SI). The SI said that the meetings were positive with few issues.

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 (error). Near misses were discussed with the member of staff at the time and were then recorded in the near miss log. One member of the pharmacy team completed a monthly review of the near miss log and shared his findings with the team. The key learning points from the near miss log review were not always recorded, which made it more difficult for the pharmacy to track any improvements made. A team member remembered one learning point had been the need to reduce distractions, such as too much talking between the team. And they believed this had led to a reduction in the errors. However, another team member said that more mistakes were made in the afternoons near the cut off point for deliveries. But the team had not looked for ways to resolve this, so some opportunities to improve may have been missed.

When patients first started using the pharmacy, they were sent a welcome pack, which included details about the service and its complaints procedure. This information was also available on the pharmacy website. People could also complain via the NHS Trust. The SI had an oversight of all complaints, but they were mainly resolved by the CST. The pharmacy had recently completed a trial customer survey. The feedback had been generally positive. The pharmacy was intending to complete regular surveys of all people who had used the service for more than six-months. It had also received a number of 'thank you' letters from people using its service.

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. Professional indemnity insurance was in place. Pharmacy team members had completed safeguarding training, relevant to their roles and responsibilities. The team member asked, explained the signs of concerns she would look for and knew how to deal with them and who to report them to.

Principle 2 - Staffing ✔ Standards met

Summary findings

Members of the pharmacy team effectively manage the pharmacy's workload. They have the training they need for the jobs they do. And the pharmacy reviews the number of people and skills it needs to make sure the team remains appropriate as its workload and services change. Team members can provide feedback to help improve the pharmacy's services and know how to raise concerns if needed.

Inspector's evidence

During the inspection, the pharmacy teams effectively managed the workload. The dispensary team had two pharmacists, three pharmacy technicians, one of whom worked as an accuracy checker (ACT), five dispensing assistants and three trainee dispensing assistants. The CST had one pharmacist, one pharmacy technician, six dispensing assistants and five trainee dispensing assistants. The SI had worked with a training provider to produce a bespoke training course for dispensers to reflect the nature of the pharmacy business. The SI explained that members of the CST completed the dispensing assistant course, as well as customer service training, so that they could have a better understanding of people's problems and of the services the pharmacy provided. The SI explained that they were continuing to recruit new members to the team as they expanded. New members of staff were required to complete a robust induction plan, starting with customer service training, and were required to be signed off against a competency framework.

The SI said there was an open culture with regular team meetings, a suggestion box for ideas and an annual staff survey. Recently the repeat prescription form had been changed following a team member's suggestion to make the form clearer for the NHS Trusts. When asked, members of the team said they felt supported and felt able to raise concerns if necessary. They had an annual review where they were able to give and receive feedback. Staff said they were supported in their development with one team member explaining that after making a request she had been enrolled on a pharmacy technician course. In addition, team members received in-house training to help keep their skills and knowledge up to date. This had included training on how to speak to people accessing the service who might be particularly vulnerable.

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. The pharmacy's modern websites provide appropriate information and a portal for patients and professionals to access information and communicate with the pharmacy.

Inspector's evidence

The pharmacy premises was located 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 worked in a separate room that was a reasonable size for its purpose. The dispensary was also an appropriate 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 had two websites. One was homecare-pharmacy.co.uk and the second Fertilty2u.com focused on its fertility medicines. The pharmacy's websites included appropriate information about its services and contact details. They also included details of the senior management and the SI's name and registration number. The pharmacy websites had different parts, called portals, which could be accessed by people using the service, NHS Trusts, or the nursing provider. Access to these portals was managed appropriately. The website offered some non-prescription fertility treatments for sale. The SI said this service had stopped and agreed it would be removed from the website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy services are well managed to help make sure people receive their medicines safely and on time. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely and it knows the right actions to take if medicines or devices are not safe to use 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 they told the person who their homecare provider (pharmacy) would be. The trust then completed a registration form and posted it to the pharmacy along with the person's first prescription. The registration form included signed consent from the person agreeing to use the service. Subsequent prescriptions were also posted to the pharmacy. Most prescriptions from private fertility clinics were sent electronically.

When the pharmacy received a registration form, the CST created a patient record and then sent the patient an email which included a welcome pack with information about the pharmacy and the services it offered. The welcome pack was currently only available in English, which could make it difficult for patients of different nationalities to fully understand the service. The CST also tried to phone the patients to introduced themselves and explain the service. If the trust made the pharmacy aware that a patient had a language barrier then they arranged a translator. Although the trusts initially sent out information to the patient, the pharmacy had found that people often did not fully understand how the service was going to work. The SI said that people who had been initially spoken to by the CST generally had a better overview of what to expect and how things worked logistically.

People could contact the pharmacy by phone or email or through a patient portal on the website. On the portal they could update personal details, such as their address, select a delivery date, and view details about their prescriptions and previous prescriptions. There was also access to patient information leaflets and instructional videos about their medicines. People were provided with a buffer of two weeks medicines in case there were any delays in the system. The pharmacist who completed the clinical checks of the homecare medicines was based in the CST room. This meant that if a person had a query that the team were not able to answer it was easy to seek advice from the pharmacist or for the pharmacist to speak directly to the person.

The pharmacy did not provide nursing care but if a prescription indicated that a visit was required the CST ticked a box on the system which gave the nursing care provider access to the necessary information for that patient. The nursing provider then updated the system when a visit had been arranged. If a visit had not been arranged by the date the patient's medicines were due delivery this was followed up with the nursing provider by the pharmacy. The SI explained that when the pharmacy had started providing their service they had been aware that there could be delays in arranging the initial training by the nursing care provider. The communication processes they had in place helped to ensure that there were only a very small number of delays . Also if a person contacted the pharmacy about nursing care the CST would contact the nursing provider to help make the system work as smoothly as possible for the patient.

The pharmacy ordered repeat prescriptions for people. The computer system automatically sent an

email to the NHS trust 6 weeks before the prescription was due. And a chaser was sent every two weeks if the pharmacy still had not received the prescription. Then the CST rang the trust to chase the prescription and if necessary, escalated it to a more senior member of the team. The pharmacy monitored the number of prescriptions they needed to chase and raised any recurring concerns in service review meetings. But overall, the number of late prescriptions was small. In addition to this the pharmacy also provided each trust access to information through another portal. The portal listed prescriptions that were due in order of the most urgent. The trust could also access person specific data such as their delivery dates, communication history and any problems contacting the person about missed deliveries or doses.

Prescriptions received by the pharmacy were clinically screened by a pharmacist to ensure correct quantities and dosage had been prescribed. The pharmacist did not have access to the person's hospital records, so relied on the checks made by the Trusts. Most prescriptions sent to the pharmacy had been clinically screened by the hospital's clinical team. But at least one trust did not provide a clinical check. The pharmacy had queried this and had been told that a clinical check was not required. Any missing information or queries relating to the prescriptions, such as unusual doses or wrong formulation, 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 24 to 48 hours, after which they would send a chaser.

The pharmacy's workload was organised by the delivery dates, and this was tracked to make sure it was completed on time. The pharmacy kept a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label to help 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 them being mixed up. Dispensed medicines were then placed in a sealed secure box and labelled for delivery. Medicines requiring cold storage were put in a fridge while waiting for despatch.

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. The team understood the particularly time sensitive nature of the fertility service the pharmacy provided and used same day or next day delivery when required.

The CST contacted people to make arrangements for deliveries. If there was no response, they would try to contact the person three times, after which they contacted the relevant trust to make sure that the person still required the medicine. Along with written patient information leaflets (PILs) QR codes were included on the delivery note linked to electronic PILs or instructional videos about people's medicines where these were available. The pharmacy used two other courier services to deliver to areas that the main courier could not deliver to. When the other couriers were used, medicines that required cold storage were placed in special containers with ice packs. The pharmacy team explained that these containers had been tested to ensure that they remained cold for at least 48 hours.

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. But the medicines returned from the other two delivery services should not be reused. However, this was not clear in the SOP, and when team members were asked about this, they were unsure about the different processes for the different couriers. The superintendent agreed to review

the SOP and immediately make sure the team understood the correct process. The SI subsequently completed an audit of returned medicines and confirmed that no medicines returned by these couriers had been reused.

Medicines were stored on shelves in their original containers. All medicines were scanned into the system which meant that the computer automatically tracked the expiry dates and chose the shortest date medicine to be supplied. The team also made sure that the medicine had a sufficiently long expiry date for the time period that the person was going to use it for. A check of a small number of medicines did not find any that were out of date. A pharmacy team member explained the process for managing drug alerts which included a record of the action taken. Batch numbers were recorded so that people could be contacted in the event of any recalls or safety issues.

The pharmacy had a tracker which predicted the amount of stock medicines they would require for the next few months. Biosimilar medicines were obtained directly from the contracted pharmaceutical companies. Most medicines the pharmacy supplied were specialised and could only be supplied by designated pharmacies. 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.

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 fridges were in good working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacist said that the pharmacy's portable electronic appliances had been recently tested to make sure they were safe.

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.