General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sciensus Pharma Services Limited, Fifth Avenue, Centrum 100, BURTON-ON-TRENT, Staffordshire, DE14 2WS

Pharmacy reference: 1084907

Type of pharmacy: Closed

Date of inspection: 26/04/2022

Pharmacy context

The pharmacy business operates across the UK delivering specialist services, including supplying medicines and ancillary equipment to people in their home. The pharmacy makes supplies against prescriptions issued from NHS Trusts and clinics across the UK. This includes a range of treatments for medical conditions such as cancer and rheumatoid arthritis. This was a follow-up inspection to one undertaken in November 2020. The inspection took place during the COVID-19 pandemic.

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 generally identifies and mitigates the risks to provide safe and effective delivery of its services. And it suitably protects people's confidential information. The team members act competently when issues occur that affect the safe delivery of pharmacy services. The team members use the information they record about errors to take prompt and appropriate action to help prevent similar mistakes happening again. People using the pharmacy services can typically raise concerns using several communication tools.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy had a one-way system when entering the building. Team members wore Personal Protective Equipment (PPE) in the form of face masks and had access to hand sanitiser. The pharmacy required team members to self-isolate when they tested positive with COVID-19. And to complete a lateral flow test if they developed COVID-19 symptoms.

Healthcare at Home had a wide range of standard operating procedures (SOPs) that provided the teams with information to perform tasks supporting the delivery of services. The SOPs were developed by a dedicated Healthcare at Home team and signed off by the Superintendent Pharmacist. The SOPs described the roles and responsibilities of the team. The SOPs were read by team members and senior team members monitored compliance with the SOPs.

At the beginning of October 2020, and prior to the last inspection, the pharmacy began an IT upgrade designed to amalgamate different IT platforms into one IT system. Soon after the launch of the IT upgrade the system became unstable and was working slower. The pharmacy hadn't identified all likely issues through its risk assessment. This impacted on the processing of prescription orders causing a backlog of orders in the system and affecting the delivery of some people's medicines. Several people reported problems when contacting the pharmacy to ask about the delivery of their medicines as business continuity of ways of communication proved insufficient on occasions. The pharmacy business reacted to the issues and rectified them over time. The pharmacy undertook an investigation and review of the IT issues experienced after launching the upgrade. And the senior leadership team met regularly to discuss what went wrong, to also identify what had worked well and to resolve issues. One of the outcomes from the investigation and review was a decision to delay the launch of the next IT upgrade and then to continue the roll out to smaller groups of people in particular therapy groups.

Since the last inspection the company had continued with a more controlled roll out of IT systems. The latest upgrade included changes to the pharmacy systems and operations. In preparation for this the senior pharmacy managers provided regular updates through an internal newsletter to team members. The pharmacy operations director had oversight of all aspects of the upgrade and authorised which groups of people would be moved over to the new system and when. This ensured the appropriate safeguards and governance were in place for a safe transfer. Senior pharmacy managers held three meetings a day. They identified issues such as bottlenecks of work and IT issues raised by team members. They also agreed the next cohort of people to transfer over and this took place overnight. Examples of issues that triggered delay to the roll out included the slow uploading of prescription orders and subsequent risks of delay in processing orders. This showed learning from the previous way

of working and rollout. The gradual roll-out of the upgrade meant the pharmacy was operating two systems. The pharmacy recognised risks with this and provided support to the team to manage this. Senior pharmacy managers had agreed that people with complex and bespoke treatments would transferred over to the new system at the end. Approximately 55% of people using the pharmacy had been transferred to the new system.

Following the IT issues in October 2020 the pharmacy team developed an end of day reconciliation process to help check people received their medication on time. The pharmacy had recognised it needed to be more proactive in identifying risks to delays in people receiving their medicines. The process usually identified prescription orders that were not ready for delivery and orders that were not at the stage of processing they should be. This triggered a response from a trouble shooting team to investigate and resolve. The team completed the reconciliation process before the deliveries were due out. Senior team members analysed reconciliation process reports. They generally used the data to check for any impact from the IT upgrade on the processing of prescription orders. And to identify key areas of concern that could be used to inform changes to the upgraded IT system and training. For example, ensuring the Prescription Managment team completed the process correctly when registering people new to the service. Senior managers monitored incidents of people missing their doses through weekly reports that were shared with the teams. These reports showed the main root causes that resulted in the person missing their dose and which team was involved. The managers used this information when implementing changes to ensure similar incidents didn't re-occur. The senior team members regularly met with stakeholders to discuss issues and concerns.

The pharmacy kept electronic records of errors that occurred during the dispensing of prescriptions, known as near misses. The near miss record captured details of the error along with details of the team member who had made the error and the actions taken to prevent similar errors. The pharmacy team also completed reflective practice forms in response to errors. The pharmacy managers regularly reviewed the records to ensure they were correctly completed and showed individual reflection on the error by the team member involved. For example, if a team member regularly recorded the action to prevent the same error as 'double check'. The pharmacy managers gave feedback to the team following these checks and shared emerging patterns. This enabled all team members to consider the root cause of the near misses and to identify opportunities to introduce processes to reduce similar errors. The pharmacy managers encouraged all team members to discuss their errors and share ideas. The teams in other areas of the pharmacy operations followed similar processes to record and analyse errors. The pharmacy team reported that since the warehouse team had moved to using the new IT system and scanned the manufacturer's barcodes with handheld devices, the picking error rate had significantly reduced. All teams were involved with the regular patient safety meetings when incidents, trends, and corrective and preventative actions (CAPA) were discussed.

The pharmacy had upgraded its telephone systems following the last inspection in response to concerns raised by people having difficulty contacting the pharmacy. This enabled people to choose several options including an option for urgent supplies to ensure their query was given priority. The pharmacy provided a dedicated emergency phone line for prescribers and clinics to use when urgent prescriptions were required. The pharmacy had recruited team members into the CPS team and had trained several team members from other teams to support the CPS team when needed. Senior managers monitored the contact the pharmacy had with people to ensure it was timely and correct. The pharmacy allocated codes to calls so the senior managers could see the reason the person had made the call and to analyse for trends. In addition to the upgraded telephone system the pharmacy website had a live chat facility that was reported to be well used and to have helped to reduce waiting times for phone calls. The pharmacy had developed a mobile phone application (App) for people to use. This provided people with reminders to order their medication and to receive updates on the delivery of their medicines. The pharmacy's website provided people with information on how to raise a concern. And it monitored

social media for comments and feedback.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) logs met legal requirements. The pharmacy's website displayed details on the confidential data kept and how it complied with legal requirements. All team members completed annual training about the General Data Protection Regulations (GDPR). They separated confidential waste for shredding offsite. The pharmacy had safeguarding procedures in place and guidance for the teams to follow. The pharmacy provided annual safeguarding training to all team members. The pharmacy employed a safeguarding officer who was available for team members to contact. The delivery drivers reported safeguarding concerns to the team for the appropriate action to be taken.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large and experienced team with a wide range of skills to support its services. Its team members work well together, and they support each other in their day-to-day work. The pharmacy takes responsibility to actively encourage team members to share ideas and provide feedback when it introduces new systems and processes. The pharmacy consistently provides ongoing training and development opportunities for team members to progress their knowledge and skills. The team members benefit from identifying areas of their own practice they wish to develop through feedback on their performance. So, they can develop in their role.

Inspector's evidence

The pharmacy employed many full-time and part-time team members who were based either at the registered pharmacy or the other site owned by the company. The pharmacy team was supported by the Superintendent Pharmacist, the pharmacy operations director, a pharmacy operations manager, and pharmacy managers. The pharmacy employed several accuracy checking technicians (ACTs), pharmacy technicians and qualified dispensers. Due to challenges with recruiting into certain pharmacy posts the pharmacy continued to contract several locum team members. Most of these team members were familiar with the pharmacy operations and were supported by the experienced team members. The managers reported the challenges with team numbers had not affected performance or the team's ability to handle the workload.

The team members were observed working in an organised and calm manner. The team members from both sites generally worked with each other to manage potential issues that could impact on service delivery and the experience of people using the pharmacy services. The responsible pharmacist (RP) signed in at the registered pharmacy was based in the dispensary and had overview of the dispensing and checking process. They spent their time working alongside another pharmacist clinically checking electronic prescriptions on the new IT system. They also answered queries on prescriptions raised during the dispensing process and they supported the dispensary team.

The pharmacy had included an experienced ACT with trialling the new IT system and to support the training of colleagues before the system went live. The ACT worked closely with the pharmacy managers who tasked the ACT to identify and feedback any issues when reviewing the processing of prescriptions within the upgraded system. For example, the ACT identified the positioning of the scanned prescription on the new system made it difficult for team members to read all the information needed when they were dispensing and checking the prescription. As a result, improvements were made to the document layout so the information needed was clearly visible. The ACT and pharmacy managers checked the changes made before the release to ensure they reflected what had been highlighted. The pharmacy utilised the skills of other team members to help with the IT upgrade. For example, the pharmacy had used the IT skills and knowledge of one of the pharmacists to test the IT changes after they were implemented.

The pharmacy provided new team members with an induction programme. This included general information for all team members and specific training related to the role. For example, the pharmacist received training on the different therapy groups the pharmacy provided medication for and IT training. They also shadowed one of the experienced pharmacists before working alone. New team members

received regular one-to-one sessions. The training for the delivery drivers included manual handling. The pharmacy had a dedicated learning and development (L&D) team who created a range of training modules and training tools such as videos for the team members to watch and learn from. The L&D team typically liaised with line managers to monitor team members progression with the training modules. They worked closely with managers to identify and prepare new training modules. The L&D team was involved with the review of issues such as patterns emerging with errors to see what training opportunities could be created to prevent similar errors from happening again. They also reviewed if the training already provided needed updating. The pharmacy provided team members with annual performance reviews. It encouraged them to discuss career progression and any support needed for further training.

The pharmacy held regular team meetings and used a popular online meeting platform to mostly keep team members up to date with changes. The pharmacy used the platform for team members to provide feedback. It promoted the platform as an open forum for team members to raise concerns, share ideas and suggest changes to processes. The pharmacy generally responded to feedback. For example, the pharmacy operations manager had used their experience from other roles to introduce timers to remind the pharmacy team to ensure medication requiring storage was returned to the fridge. The ACTs working in the dispensary used a secure social media group to share information on new medicines and treatments and learning from errors. The ACTs had identified that the dispensing labels generated by the new IT system didn't have all the information they expected to see and the system was updated after this feedback.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are large and appropriate for the services the pharmacy provides. And the pharmacy is suitably clean, hygienic, and secure.

Inspector's evidence

People could not directly access the registered pharmacy premises which were in a large business unit. The unit provided plenty of space for team members to work and for storing stock. The team members kept the areas clean and tidy and they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had separate sinks for the preparation of medicines and hand washing with hot and cold water available for hand washing. And it provided sufficient staff facilities. The pharmacy had systems installed to secure the premises. And it had an intercom to manage visitors and access to the premises. The pharmacy had clearly marked fire exits.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally uses its systems and dedicated trained teams to support the safe delivery of its services. The pharmacy adequately reviews its systems and processes to ensure its services safeguard the health and well-being of people using its services. And it largely takes appropriate action to ensure the delivery of its services remain safe and suitable. This is especially during periods of change to its systems. The pharmacy gets its medicines from reputable sources and the team members store and manage them properly.

Inspector's evidence

The pharmacy business provided a range of advanced services delivered to people in their home. The services provided by the pharmacy team included processing and dispensing prescriptions and supplying medicines and ancillary items such as sharps bins. Prescriptions were supplied from NHS Trusts and clinics across the UK. And were mostly for specialist medication to treat a range of medical conditions such as rheumatoid arthritis and cancer. The pharmacy received many paper prescriptions on a variety of templates. The pharmacy was aware of the risks this caused and was working with a few organisations to increase the number of prescriptions sent electronically. And to develop a standard prescription template.

The pharmacy's IT upgrade included processes and technology aimed to improve the efficiency of entering the paper prescriptions received into the pharmacy's system. The team scanned the prescriptions in batches and checked the accuracy of the data inputted at several stages of the process. When receiving a prescription to initiate treatment and setting up a new account the person's NHS number was a mandatory field. This unique identifier helped reduce the risk of errors from people with similar names. The team understood the importance of adding the person's diagnosis accurately as this determined the welcome pack the person received and the scheduling of nursing care. The pharmacy had a dedicated team to manage prescription queries that arose. Many queries required contact with the prescriber which sometimes caused delay to the dispensing of prescriptions. The team kept a record detailing when queries was sent and the type of query. And typically used this information to check whether responses had been received. The team escalated queries from email to phone calls to help prevent further delay to the processing of prescriptions. The pharmacy used the end of day reconciliation process to identify and investigate any delays to the dispensing of prescriptions.

The workload was organised so each pharmacist in the team was allocated a batch of prescriptions to clinically check. The pharmacists referred to information such as notes left on the person’s account and previous checks. And updated the notes section when new information was obtained. The pharmacist also undertook an accuracy check to ensure the correct information had been transcribed from the prescription.

The pharmacy generally planned deliveries for two weeks before the person needed to start their next supply. The person held buffer stock at home, and this typically helped mitigate risks of them running out of medicines if there were delays in obtaining and processing prescriptions. The upgraded IT system enabled people using the pharmacy’s mobile phone application (App) to respond to requests from the pharmacy for their current buffer stock level. The pharmacy still relied on the system of contacting the person by email or telephone to confirm their buffer stock levels for people who didn’t use the App.

This method of establishing the buffer stock had occasionally caused some people to miss their dose of medication as the information the pharmacy held about the person's buffer stock had been incorrect. Urgent prescriptions were prioritised, for example in response to a person contacting the pharmacy advising they had little or no medication left. The team processed urgent prescriptions separately from the day-to-day workload so people could receive their medicines the same or next day.

The updated IT system had a live stock count and orders were booked in on receipt. This meant there was the facility to allocate and reserve dedicated stock for each prescription order. This also meant when the pharmacy was aware of upcoming stock shortages then amended amounts could be shared out to different people's prescriptions to reduce the risk of individual people receiving no stock of their medicines. A dedicated team of dispensers generated picking order sheets after they were confirmed by an ACT. The pharmacy typically printed batches of prescription orders in specific treatment groups. This allowed medicines to be picked in the warehouse in greater volumes. Some lower volume and more complex treatments were picked to individual patient level. These were picked into individual baskets, kept in a separate area of the warehouse and then transported to the dispensary in these baskets to prevent mix-ups.

Each team member picking stock in the warehouse had a unique log in number for the hand-held devices they used to scan the manufacturer's bar codes of the stock picked. This provided an audit trail of who picked the stock and identified issues that might indicate a team member needed further training. The hand-held device directed the team member to the location of the stock in the warehouse. They scanned the bar codes on the location shelf and then the manufacturer's barcode on the product to ensure they matched.

Team members in the dispensary were allocated to one of the many workstations. Each station team included a dispenser, an ACT and a suitably trained team member bagging the checked prescriptions. The ACT was responsible for the team at the station. Each workstation had a computer and a monitor providing the dispenser and ACT with access to the information they needed to perform their tasks. The dispensers used baskets to separate different people's medicines. They scanned the manufacturer's barcodes on the product and the barcodes printed on the dispensing label to check both matched the prescription. The system highlighted any issues and queries with scanning, and it paused the processing of the prescription until the issue was resolved. The dispenser attached details of the query to the prescription before handing it to one of the pharmacists working in the dispensary to resolve. The system generated a unique packaging identity label for each prescription and this indicated if the stock was to be kept at room temperature or chilled. The team at the workstation used a timer set to 30 minutes to ensure items requiring cold storage were not out of the cold chain control for too long. When the timer sounded one of the team used a walkie talkie to contact a member of the warehouse team to collect the dispensed and checked items. This was witnessed and the warehouse team member returned them to the fridge room in a timely manner.

The pharmacy had a dedicated area in the warehouse for the delivery drivers where a notice board displayed key information. This included the use of failed delivery cards and a requirement to photograph the door on delivery. In addition to the delivery area in the pharmacy the company had several delivery depots around the UK. Each depot had an operations manager to support deliveries, resolve queries and manage failed deliveries. The pharmacy's new IT system enabled the teams to allocate the completed order to a specific depot which also triggered the track and trace process. People usually received a text message advising the delivery was on its way and when there was a delay on route. The pharmacy had reviewed the performance targets for deliveries to reflect the different environments the drivers would encounter. For example, delivering to a flat in a high-rise building would take longer than a delivery close to the van. The pharmacy reported the main reason for a failed delivery was the person wasn't at home when the delivery was attempted. The pharmacy asked people

for a second contact number in case they were out. Reports showed that on occasion the date of delivery had not been confirmed with the person and contributed to failed deliveries. The pharmacy management team monitored these findings to learn from them. The pharmacy used a compliance scoring system at each depot level to show the teams' compliance with the processes.

The pharmacy obtained its medication from several reputable sources. The warehouse team allocated received stock to specific locations as part of the bar code system. Expiry date information was held in the system so stock with the shortest expiry date was allocated to be used first rather than stock with longer expiry dates. Information on split packs was held in the system so these were used first. The system identified in the early stages of processing the prescription any issues with the availability of stock. In addition to expiry date information the pharmacy's system held the product's batch number. This meant the team could respond appropriately to recalls and alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has equipment that is well maintained to help ensure the safe supply of medicines. The pharmacy's systems suitably protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the pharmacist team with up-to-date clinical information. The pharmacy ensured the introduction of new technology to support the effective delivery of its services was fit for purpose and that team members had received appropriate training. The pharmacy had large cold storerooms to hold medicines requiring storage at fridge temperatures. The team members regularly monitored the temperatures of these rooms to ensure they were within the accepted range. The cold storerooms were also connected to an alarm if the temperature went outside the accepted range. The pharmacy computers were password protected and data was encrypted to ensure people's confidential information was protected.

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.