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: Homecare Medicines Service

Date of inspection: 13/08/2024

Pharmacy context

The pharmacy provides a homecare medicines service which involves delivering ongoing medicine supplies direct to people's homes. All 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 are not open to the public. The pharmacy has an NHS contract to enable it to dispense NHS prescriptions when required. This is one of two pharmacies providing homecare medicines services owned by the same company.

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 identifies and 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 it operates. Members of the pharmacy team follow written procedures to help them work effectively and they record their mistakes so that they can learn from them. Then they make changes to help prevent the same mistakes from happening again.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that covered all its services and were regularly reviewed. They explained the processes the team was expected to follow, and some had accompanying work instruction documents. Regular reviews of the SOPs took place with input from the department managers. Records were kept confirming that team had read and understood the SOPs relevant to their roles.

A risk register was maintained and managers regularly identified and documented risks within their departments. Risk assessments had been completed for all medicines that the pharmacy supplied which included clinical information, about the medication, storage requirements and the conditions they were prescribed for. Team members explained how they mitigated some of the risks that had been identified. For example, any delays in the supply of oncology medicines could have a significant impact on the patient's treatment progression. So, the dispensing and supply of oncology medicines was prioritised. And the pharmacy ensured there were enough team members to manage any increase in the number of oncology prescriptions received. But the risk assessments did not always include details of the actions taken to mitigate the risks which meant team members may not always be clear what was expected of them.

The pharmacy regularly monitored its performance and shared the results with all team members and the NHS Trusts. The patient services team completed audit of the quality of calls that included listening to the conversations. The results were used to show what worked well and what improvements could be made. For example, the patient services team had been provided with specific questions to ask when a person wanted to return medicines so the correct process could be followed.

The pharmacy team recorded errors that occurred before people received their medication, known as near miss errors. Team members discussed what happened and why. Then the team member responsible for the mistake completed a reflective practice form. For example, some errors with incorrect quantities had been linked to members of a team that transcribed the prescriptions not knowing which medicine packs could be split and which could not. So, they had spent time with colleagues in the dispensary to develop their knowledge and understanding.

Errors identified after a person received their medicine were known as dispensing incidents. The pharmacists assessed these to establish the impact of the error and determine what follow up action was needed. They investigated the incident and recorded the outcome which included a duty of candour report. The outcome was shared with team members so they could learn from it and make changes to their practice. And the team member responsible completed a reflective statement. A recent example involved a dispensing label directing a subcutaneous dose instead of an intravenous

infusion. The direction had been selected from a drop-down list embedded in the system. Following the incident, the list had been removed from the system so team members had to always check the prescription to confirm the route. Learnings from near misses and dispensing incidents were shared with all teams at weekly safety briefings and in a monthly bulletin.

The pharmacy's website explained how people could raise complaints and how they were managed. This information was also in a welcome pack sent to new patients and people could give feedback on the pharmacy's patient App. The patient services team members resolved complaints within their competence and escalated calls as necessary. People had given feedback that they wanted more information on how their complaints were handled, so team members investigating a complaint now spoke to the person, explained their role and asked what resolution they expected. The pharmacy sometimes received complaints about call waiting times and delays answering the phone were identified through call data analysis. Maximum wait times were reviewed and people who had reported an issue were contacted for feedback. The pharmacy regularly sought feedback from patients through several channels including social media platforms, surveys and customer satisfaction scoring. For example, asking a person to rate their experience after a telephone call. Managers reviewed the information provided so appropriate action could be taken. For example, they listened to recordings of telephone calls when people rated their experience as three out of five or less. And individual feedback was provided to the team member including how they listened and the tone of their reply.

The pharmacy had current professional indemnity insurance. Responsible Pharmacist (RP) records were appropriately maintained, and the correct RP notice was displayed. The pharmacy website explained how it handled confidential data and displayed a privacy notice. This information was also contained in the welcome pack. All team members received data protection training. Confidential waste was collected separately from general waste and shredded offsite. Any incidents involving people's confidential information were investigated and reported. The pharmacy had safeguarding procedures in place, and team members regularly completed training relevant to their roles. They provided an example showing how they had responded appropriately when a safeguarding concern had arisen. The delivery drivers reported concerns back to the pharmacist team if they had concerns about people they delivered to, so the team could take appropriate action.

Principle 2 - Staffing   ✔ Standards met

Summary findings

The pharmacy has a large and experienced team with an appropriate skill mix for the services it provides. It considers staffing levels as part of future workload planning and completes recruitment and training before any additional work is undertaken. Team members work well together in a supportive environment, and they receive ongoing training and development to help improve their knowledge and skills. They can demonstrate how their feedback is used to inform the way that the pharmacy operates

Inspector's evidence

The pharmacy team at this pharmacy included 25 pharmacists, 19 pharmacy technicians, 14 of whom worked as accuracy checkers (ACPT) and several qualified dispensers. The team was supported by the Superintendent Pharmacist (SI) and senior managers. Some team members working in other areas, such as the transcribing team and the warehouse team were qualified dispensers. So, they could support colleagues the dispensing team when needed. The pharmacy was one of two registered pharmacies owned by the same company and a patient services team of around 185 members worked across both pharmacies.

The pharmacy regularly reviewed the number of vacancies and sought feedback from people who left its employment to identify whether changes should be made. Pharmacists had given feedback that they didn't get quality time with managers. In response the pharmacy reduced the number of team members reporting to each line manager so they had more time to interact. This had been positively received and the number of pharmacists leaving had decreased. Team members worked well together and supported each other to manage their workload. Managers regularly analysed the workload and used the pharmacy's data system to arrange team rotas and adapt to workload such as an increase in call volumes.

New team members followed a three-month induction training programme and did not take on responsibilities until they were signed off as competent. Newly employed pharmacists did not take on the RP role until their induction was completed. So, they had time to develop their skills and knowledge. Team members were appropriately trained for their roles. They were allowed protected time at work to complete additional training such as new medicines. Pharmacists were encouraged to access external training provided by NHS Trusts and pharmaceutical companies to keep their knowledge up to date.

Team members received feedback in one-to-one meetings with their managers and discussed opportunities for development. And the pharmacy encouraged positive feedback to recognise when team members performed well. Regular team meetings and bulletins were used to highlight key issues and share updates. The pharmacy had an employee assistance programme.

The pharmacy had performance targets in place, but team members reported they didn't feel under pressure to achieve them. Team members were able to raise concerns with their line manager or senior managers, including the SI, and there was a whistleblowing policy in place. The pharmacy regularly invited team members to provide feedback, both informally and by completing a yearly staff survey. The results of the survey were briefed to the senior leadership team.

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

The pharmacy premises were in a large business unit which was not open to the public. The pharmacy's website provided details on the services offered and how to contact the pharmacy. The pharmacy was clean and tidy, and provided plenty of space for team members to work and for storing stock. Floor spaces were kept clear to avoid trip hazards. The lighting was maintained to appropriate levels and room temperatures were monitored and controlled. The pharmacy had separate sinks for the preparation of medicines and hand washing with hot and cold water available. 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 is well organised, with dedicated teams working well together to support the effective delivery of its services. The pharmacy communicates well with people to help make sure they receive their medicines when they need them. It gets its medicines from licensed suppliers, and it keeps them in good condition so that they are fit for purpose.

Inspector's evidence

The pharmacy's services were mostly funded through contracts with pharmaceutical companies. Some funding came through service level agreements with NHS Trusts. All patients were initially assessed as being suitable for the service by the teams at the NHS Trusts before being referred to the pharmacy. The pharmacy also performed its own assessment before registering a patient. And any patients identified as not suitable were referred back to the Trust.

When the Trust referred a new patient they completed a registration form and sent it to the pharmacy attached to the relevant prescription. But sometimes Trusts sent new prescriptions without the registration form, so they were only identified as new patients when the prescription was processed. This then caused delay because further information had to be requested. This issue had been fed back to Trusts when there had been frequent problems and the pharmacy had explained the impact it had on the service.
Sometimes registration forms were sent with prescriptions that needed to be supplied sooner than the agreed timescales. These were flagged as priority at the point of registration and marked as urgent. Ancillary items such as needles were supplied at the pharmacy's discretion, in accordance with the manufacturer's requirements.

When people first registered they were sent a welcome pack detailing the services offered and explaining how to contact the pharmacy. This information was also available on the pharmacy's website. There was also an option for patients to set-up a secure online portal which could be used to confirm delivery arrangements, track the progress of prescriptions, advise how much medicine they had left and order ancillary items. When a new patient had been registered the patient services team telephoned them to confirm their details and answer any questions. Most Trusts required the pharmacy to contact new patients within five days of receiving the registration form and to deliver their medication within a further five days.

Most people contacted the pharmacy by telephone or email. This was managed by the patient services team. The pharmacy's telephone system had a call-back option people could use if the line was busy and there was a priority line for urgent calls from patients. The pharmacy monitored inbound calls and the time to answer a call. Most calls were answered within the agreed timescale. The pharmacy's email system identified key words such as "urgent" and "overdue" so they were actioned first.

Most of the prescriptions the pharmacy received authorised several supplies before a new prescription would need to be ordered. The frequency of supply differed depending on the medicine prescribed. But sometimes prescribers issued prescriptions for different delivery frequencies than had been agreed. To avoid this, different pharmaceutical companies had developed prescription templates for all prescribers to use when prescribing their products. However, some Trusts chose not to use them and as a result,

the pharmacy often received prescriptions that were incorrect or incomplete, which sometimes caused delays.

The pharmacy had an online portal for Trusts to use which held detailed information including patients on hold and the reasons why. Trusts could see prescription requests and track a prescription's progress along with delivery information. And they could complete actions such as putting patients on hold. The pharmacy had a dedicated telephone line for Trusts but encouraged the use of the portal as it could answer most questions and was more time efficient. Most Trusts now used the portal in preference to the telephone. Those that still used the phone had been encouraged to use the portal and offered extra training. A group of Trusts' representatives regularly met with the pharmacy to highlight what worked well and suggest areas for improvement. All Trusts were invited but some declined to send a representative. Some representatives had highlighted that Trusts didn't always know when patients were due blood tests. So, the pharmacy had developed prompts to advise Trust teams when a test was due. This had helped to ensure test results were available at the time the prescription was generated. A benefit for the pharmacy was notification on the portal when patients were moved to another pharmacy. On receipt of this information the pharmacy confirmed the change with the Trust and advised the patient.

The pharmacy had helped develop systems to enable prescriptions to be sent electronically. A lot of prescribers now used this facility but many paper prescriptions were still being received. This meant that any problems in the postal system could cause delay. The prescriptions were normally received in bundles, accompanied by a form confirming the prescriptions had been checked and validated by the Trust's homecare team. The pharmacy transcribed the prescriptions on to its system and generated dispensing labels. An Artificial Intelligence system was used for transcribing, which reduced the processing time. The system used three patient identifiers to ensure people were correctly identified, including their unique NHS numbers.

The pharmacists were allocated batches of prescriptions to clinically check with priority given to new patients, dose changes and overdue supplies. Clinical queries were annotated on the system and a record was kept when prescribers were contacted. For example, one record related to a medication not licensed for the patient's medical condition. And confirmation from the prescriber that it was suitable based on recognised national guidelines. The pharmacist team was running a pilot of clinically checking prescriptions for oncology medicines before information such as blood test results were received to see whether this would help reduce delays. Any queries about prescriptions that couldn't be addressed internally were sent to the Trust and responses were normally received the same day. If no response was received the pharmacy team would chase up. Trusts that regularly had slow response were notified and the pharmacy team tried to work with them to build better relationships and identify appropriate contacts.

Once a prescription had been transcribed a picking team in the warehouse selected the required stock medicines from a printed order, then passed them over to the dispensing team. Medicines were stored in specific locations in the warehouse and the correct selection was confirmed using barcode scanning. The dispensary had separate work stations designated for fast moving, complex and oncology. Team members worked against picking sheets containing patients' details and the medicines to be dispensed. Urgent prescriptions were highlighted on green picking sheets for the team to prioritise. Dispensing labels had unique bar codes that were scanned at each stage of the process to reduce the risk of the wrong person's record being selected and to provide an audit trail. Team members used a 30-minute timer to ensure items requiring cold storage were not out of the fridge for too long. And they organised the dispensary workflow to help reduce the frequency of accessing the fridge. And to minimise the time medicines were kept out of the fridge for tasks such as labelling and checking. An ACPT completed a final accuracy check before the medicine was packaged and placed into

an area to be moved to the delivery section

A purchasing and procurement team monitored stock availability and placed orders. Batch numbers and expiry dates of medicines were recorded on to the pharmacy's system. When a medicine was in short supply the pharmacy monitored how much medication people had, and where necessary contacted the Trust teams to agree what alternatives could be given. The pharmacy generated a monthly list of medicines due to expire and team members rotated medicine stock on shelves to ensure medicines with the shortest expiry were used first. And they removed medicines from the shelves two weeks before the expiry date. The pharmacy ensured the medicines supplied to patients had expiry dates that lasted the length of time the medication had been prescribed for. The pharmacy's barcode scanning technology also helped team members to identify expired medicines. The pharmacy received alerts about medicines and medical devices via email and they were dealt with promptly.

The delivery team worked against a rota and back-up drivers were available in case of unplanned absence. Daily delivery lists included the number of deliveries, the start and finish times and the vehicle's registration number. During the delivery any rescheduled deliveries and cancelled orders were removed from the list. The drivers used an electronic device that displayed the delivery route and recorded when supplies were made. It also recorded failed deliveries including the reasons why. On returning to the pharmacy the drivers shared any issues with their manager. The team reported that most failed deliveries were because people were not at home. This was despite three messages being sent to the person including the original contact to arrange the delivery, confirmation of a delivery window the day before and to advise they were the next delivery on the route. The person was left a note and sent a message about an unsuccessful delivery. If the person contacted the pharmacy while the driver was still nearby, they could return to make the delivery. Drivers reported any delays during the delivery run so the patients could be advised. Any other concerns were shared with the patient services team. For example, if a patient refused a delivery because they had too much medication, they were contacted to find out why. The pharmacy continually reviewed whether people were suitable for the service and any who were not were referred to the Trust to make other arrangements.

Drivers had reported that their scanning and recording devices did not always work in rural areas. This meant they had to wait for a signal to proceed with deliveries which caused delays. The pharmacy was reviewing the technology and advising drivers to use their mobile phones as a temporary solution. The pharmacy had received feedback from people who had not received the next delivery message and identified that this happened when the driver was ahead of schedule. So, the system had been adjusted to prevent drivers from starting earlier than the planned delivery time. Returns and failed deliveries were placed in a dedicated area waiting for the next delivery date to be arranged. Supplies that were cancelled by the person at the point of delivery were separated from failed deliveries and were scanned as part of the re-scheduling process or put back in to stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had large walk-in fridges to store medicines. It monitored the fridge temperatures 24 hours a day using an electronic system which alerted senior managers by email and phone if the temperature went outside the permitted range. The fridge door had an alarm that was triggered if it was open for longer than 45 seconds. Each delivery vehicle was fitted with a fridge and the temperatures were regularly monitored.

The pharmacy had an IT team on site to help resolve issues. And a separate team supported projects such as the online portal and the AI system for transcribing prescriptions. The IT team and transcribing team had gradually introduced different groups of medicines into the process to allow for issues to be identified and managed. And they regularly met to give feedback and agree the next prescription types to be moved. When piloting the AI, the team identified several fields had to be manually entered because it was not clear on the prescription. This was often linked to handwritten prescriptions so changes were made to enable the AI system to correctly read handwriting. Regular confidence checks were performed on the AI system.

The pharmacy frequently backed up its data to cloud-based servers to ensure it was not lost. And it completed regular checks of its equipment to ensure it worked correctly. This included its generators that switched on automatically in the event of a power failure.

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.