General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sciensus Pharma Services Limited, Plot 7, Junction Close, Green Lane Industrial Park, Featherstone, PONTEFRACT, West Yorkshire, WF7 6ER

Pharmacy reference: 1092334

Type of pharmacy: Homecare Medicines Service

Date of inspection: 29/07/2024

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 identifies and manages the risks associated with its services well to ensure people receive appropriate care. It uses regular audits and risk assessments to review its services and improve the way it operates. Pharmacy team members follow up-to-date written procedures to help them work effectively. They respond appropriately when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy provided a Homecare Medicines Service that involved dispensing and delivering a range of specialist medicines including transplant therapy and medicines for treating conditions such as Crohn's disease. Most medicines were supplied against prescriptions issued by NHS Trusts but some were issued by private prescribers. Pharmaceutical companies funded most of the supplies of these medicines, and a few were funded directly from the NHS Trusts that the pharmacy had contracts with. At times this different funding mechanism created challenges for the pharmacy. For example, when a medicine funded by the pharmaceutical company was not available and had to be changed.

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. Records were kept confirming that team members had read and understood the SOPs relevant to their roles.

The pharmacy had completed risk assessments to identify risks associated with its services, and also completed a risk assessment before introducing new processes. The risk assessments included action to be taken to manage the risks that had been identified. For example, the pharmacy had completed a change management process when the dispensing and supply of a medication was moved from the other pharmacy owned by the company. This included increasing the cold storage facilities at the pharmacy. And team members from the other pharmacy with experience of the medicine had given training to the team at this pharmacy. These activities had been completed in time for the relocation to take place without impacting on patients.

The pharmacy regularly monitored its performance and shared the results with all team members and the NHS Trusts. For example, a recent audit of missed and delayed doses had identified that, on a few occasions, the communication with the patient about their delivery was through a text message which didn't ask the patient how much medication they had. And some patients had accepted the delivery date when they had needed an earlier delivery but had not telephoned the pharmacy to request this. So, the pharmacy was contacting these patients to advise them what to do in such circumstances and discuss alternate communication methods.

The pharmacy team recorded errors that occurred before people received their medication, known as near miss errors. Team members discussed what had happened and why, and the team member responsible completed a reflective practice form. 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. And they made sure the patient promptly received the correct medicine. The pharmacists investigated the incident and recorded the

outcome which included a duty of candor report which was shared with senior managers. The team member responsible completed a reflective statement and all team members were informed so they could learn from it and make changes to their practice. A recent example involved a medication incorrectly labelled as a loading dose that was identified by the nurse before administering the medication. The investigation revealed that the dose instructions had been annotated on the prescription but it was not clear who had done this. So, team members were reminded that if a prescription had been amended, they should check any communications with the prescriber, such as emails responding to a query about the prescription. Or to contact the prescriber if the reason for the amendment was unclear.

The records of near misses and dispensing incidents were regularly reviewed to identify learning opportunities. These were shared with all teams at weekly safety briefings and in a monthly bulletin. A recent review highlighted medicines with short expiry dates were not being marked to highlight to the patient when they would need to be used by. So, the team was instructed to place dispensed medicines with short expiry dates into a separate bag with a sticker attached advising the patient to use these medicines first.

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 that was sent to all new patients. All team members received data protection training and they separated confidential waste from general waste for shredding offsite. The pharmacy had safeguarding procedures in place, and team members regularly completed training relevant to their roles. Posters were on display reminding team members about the processes for reporting a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has an appropriate range of experience and skills to safely provide the pharmacy's services. Team members work well together, and they support each other in their day-to-day work. They discuss ideas and implement new processes to help improve the safe and effective delivery of the pharmacy's services. And team members have opportunities to receive feedback and complete training so they can develop their skills and knowledge.

Inspector's evidence

The pharmacy team consisted of 24 members including eight pharmacists, five pharmacy technicians some who worked as accuracy checkers (ACPT) and the rest were qualified dispensers. The pharmacy team was supported by the Superintendent Pharmacist and senior managers. Team members working in other areas such as the pharmacy's warehouse were qualified as dispensers. So, they could support the dispensary 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. Team members worked well together and supported each other to manage their workload. Managers used the pharmacy's data system to regularly analyse the teams' workload to arrange rotas and adapt to workload such as an increase in urgent prescriptions to be dispensed. The company continuously reviewed the workload between the two pharmacies and had moved the dispensing of methotrexate prescriptions to this pharmacy as the team had capacity to manage it.

The pharmacy asked for feedback from people who left its employment to see whether any changes could be made. Feedback from pharmacists indicated they'd not had quality time with managers to discuss issues important to them. In response the pharmacy had reduced the number of team members reporting to a manager. So, managers had more time to interact with team members, particularly on a one-to-one basis. Team members reported these changes had a positive impact and the number of pharmacists leaving had decreased.

New team members followed a three-month induction training programme that was bespoke to the individual and their role. Pharmacists new to the pharmacy did not take on the RP role until their induction was completed. So, they had time to develop their skills and knowledge. Team members regularly completed online training on subjects such as pharmacovigilance and specialist medicines. And they had protected time to complete their training. Team members received formal feedback on their performance and could discuss opportunities to develop their knowledge and skills. They also had monthly informal discussions with their manager about their progress and training needs. One team member had discussed training to be an accuracy checking dispenser and had then been enrolled on a training course.

The pharmacy regularly held team meetings where information from the company newsletter and bulletins were shared and discussed. The bulletins highlighted individual team members contributions and team members were encouraged to make suggestions. Following a suggestion from one team member the pharmacy had implemented a process for dispensing all prescriptions for medication requiring storage in a fridge at the same time. So, the medicines were not outside of the fridge temperatures for too long and to help the team manage its workload. The pharmacists and ACPTs contributed to the bulletins such as information on new medicines and patterns from near miss

reviews. One of the pharmacy technicians had changed the near miss reporting template so colleagues could capture more detailed information.

The pharmacy regularly invited team members to provide feedback, both informally to their manager and by completing a yearly staff survey. The results of the survey were briefed to the senior leadership team. A recent survey had led to the introduction of the star contributor which recognised the work of individual team members. The pharmacy had an employee assistance programme to support team members' wellbeing. In response to feedback from team members regarding support for their well-being the pharmacy had provided time for them to carry out volunteer work in their local community. The pharmacy had a whistleblowing policy that team members could access online.

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 of the services offered and how to contact the pharmacy. The unit was clean and tidy and provided plenty of space for team members to work and for storing stock. 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 suitably manages its services to help people receive appropriate care. It 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 premises were closed to the public. When people registered with the pharmacy, they received a welcome pack detailing the services offered and the options available for contacting the pharmacy. This information was also available on the pharmacy's website. People could contact the pharmacy by phone and email, and could set-up a secure online portal to communicate with the pharmacy. This could be used to confirm delivery arrangements, track the progress of prescriptions, advise how much medicine was left and order ancillary items such as needles. The pharmacy monitored how many people used the portal and took feedback to further develop it. This found that patients preferred talking to people on the phone and some people struggled to use the platform. The pharmacy received many emails each day and often experienced an increase in inbound communications especially when there were issues such as medicines shortages. This triggered the pharmacy to increase its communications with patients such as updating the online portal with details of the issues, to help reduce the volume of incoming calls. And to enable the patient services team to prioritise other calls such as patients reporting missed doses of their medicines.

The company's other pharmacy managed the registration of all new patients. New registrations were usually initiated by the person's NHS hospital trust, who provided the pharmacy with a prescription and a patient registration document. The team at the Trust was expected to provide the patient with details about the homecare services before seeking their consent for the pharmacy to provide the service. But the team reported that new patients were often unclear what to expect until they had received information from the pharmacy. There were regular occasions where the Trusts provided prescriptions for new patients without providing a registration form. So, the pharmacy did not have all the information it needed for the registration process. This meant there could be delays to the person receiving their medication while the pharmacy resolved the matter. Once a new patient had been registered, the patient services team telephoned them to confirm their details and establish whether they had already started taking the medication. The team attempted to telephone the patient on two occasions and if they were unsuccessful, they sent a letter. The referring NHS trust was informed of any difficulties contacting a patient and asked to confirm their contact details. A decision was sometimes made when a patient could not be contacted to refer them back to the Trust to provide the medication.

The pharmacy had an online portal for Trusts to use to access detailed information including accounts on hold or closed and the reasons why. Trusts could also 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 trained the NHS teams on use of the portal through weekly drop-in sessions and a monthly workshop, where the pharmacy asked for feedback and provided information on future developments. The pharmacy also invited teams from the Trusts to visit the pharmacy to see its operations and speak to team members. Many Trusts used the portal but some reported difficulties using it that were outside the pharmacy's control. This included information

governance restrictions set by the Trust and not having enough staff hours to spend time accessing the portal. So, these Trusts continued to use paper-based systems. However, the pharmacy had increased its face-to-face meetings with these teams to explain the benefits of using the portal. And to try to resolve the issues that prevented them from using it.

The company's other pharmacy received all the paper prescriptions. All the prescriptions received at this pharmacy were either sent electronically or were scanned images of the paper prescriptions received at the other pharmacy. 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 kept when contacting the prescriber. The pharmacy's contract with some NHS Trusts required all prescriptions to be processed within five days of receipt regardless of the patient's clinical risk or how much medication they were holding. This impacted on the pharmacy's internal system for efficiently processing prescriptions which was based on when the patient was due their supply. And occasionally it meant the pharmacy could not deliver other contractual obligations for example when it had to manage stock shortages. However, the pharmacy's processes enabled the team to dispense and supply prescriptions urgently, or when demanded by the Trust. For example, the receipt of prescriptions for HIV medicines was unpredictable as it depended on when the patient attended the clinic. But once the prescription was issued it was flagged as urgent and dispensed the same day.

Before dispensing a prescription, an order form was generated for the team to refer to alongside the prescription. This was checked to ensure it had the correct information and any errors were amended before dispensing started. The dispensary team worked efficiently and most orders were prepared the same day, ready for delivery. Barcode technology was used to ensure the correct medicine was dispensed. But when several packs were prescribed, team members only scanned in the first pack and then manually entered the other packs. This meant there could be a risk that if any had been selected incorrectly the error might not be picked up at that stage. However, there was a final accuracy check by an ACPT check at the end of the dispensing process that was intended to identify any errors. Team members checked the batch number and expiry date during dispensing. When medicines from the same manufacturer with different batch numbers were dispensed, the details were added to the order sheet sent with the medicine, to make the patient aware. When medicines from different manufacturers were supplied a sticker was placed on the packaging to alert the patient.

The pharmacy had a delivery team and vehicles to deliver medicines to people. New team members received specific training and were allocated an experienced driver as a buddy. Occasionally an external courier was used for urgent deliveries. The team worked against a rota that enabled back-up drivers to be available in case of unplanned absence. Drivers' routes were planned to put delivery addresses in a logical order. Drivers were set performance targets using a nationally recognised scoring system and from footage captured on the vehicle's cameras. Any complaints about deliveries were handled by the complaints team. When investigating a complaint, the complaints team and the logistics manager discussed it with the driver responsible to determine what caused the incident and how it could be prevented from happening again. The patient services team contacted the person to discuss their complaint and what steps the pharmacy was taking to resolve it. The pharmacy reported that most failed deliveries were due to the patient not being at home at the agreed time. To help manage this, the pharmacy had implemented an extra reminder for people four days before their deliveries were due, in addition to the reminders already in place. The pharmacy was also developing its IT systems to check that patients' telephone numbers were correct and to automatically identify that when a patient was under 18 there was a named adult to receive the delivery. The pharmacy collected feedback from their drivers each day and any significant information and challenges such as road works were fed back to the patient services team. Returns and failed deliveries were placed in a dedicated area waiting for the

next delivery date to be arranged.

The pharmacy's purchasing and procurement team monitored stock availability and placed orders. Batch numbers and expiry dates of the medicines were recorded on to the pharmacy's system. This generated a monthly list of medicines due to expire. 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.
When medicines with a shorter expiry date were supplied, they were highlighted so the patient knew to use them first.

The pharmacy frequently managed medicines stock shortages on behalf of the NHS Trusts, which sometimes involved switching people to an equivalent or similar medicine. Occasionally an alternative medicine was chosen by the Trust that the pharmacy could not obtain, because it was funded by a pharmaceutical company contracted to a different pharmacy. The pharmacy would liaise with the Trusts to find the best solution, which sometimes meant the patient had to be moved to the pharmacy that could obtain the medication. The pharmacy also managed stock shortages by rationing the quantities of medicines supplied to people, to help prevent anyone running out of medicines until the shortage was resolved. The pharmacy had an automated system to support this by comparing the amount of stock available to the quantities required by people over a defined period. The pharmacy could effectively manage rationing if it was given plenty of notice about an upcoming shortage. But sometimes this did not happen and details of a stock shortage were only provided a few weeks before a prescription was due. Which meant the pharmacy had little time to implement its process and inform patients and the Trusts, to ensure patients were not without their medication. The pharmacy's processes enabled it to respond promptly in such circumstances. This included communicating with patients as soon as it could to make them aware of any medicine shortages and the actions being taken to address them. And if appropriate it provided a link to the manufacturer's website for more information. People were also always offered an appointment with a nurse to help train them about any new medicine and to provide advice about medicines administration.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had several fridges and a cold room to hold medicines requiring storage at these temperatures. Fridge temperature readings were regularly taken and recorded throughout the day and a sample showed they were within the accepted range. Alarms were fitted that triggered when the temperatures went outside the accepted range. At several locations in the pharmacy monitors captured the fridge and room temperatures. The pharmacy provided team members with two computer screens so they could refer to the pharmacy's medication record for the person alongside the prescription throughout the dispensing of prescriptions. Team members had access to IT platforms to communicate with each other and with the teams working at the other pharmacy. And they were supported by an IT team who worked remotely and on site.

The pharmacy regularly 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. 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.