

Registered pharmacy inspection report

Pharmacy Name: HubRx, Unit 7, Logic Park, Skelton Moor Way,
Halton, Leeds, West Yorkshire, LS15 0BF

Pharmacy reference: 9011871

Type of pharmacy: Dispensing hub

Date of inspection: 13/09/2023

Pharmacy context

This is a large hub pharmacy providing offsite dispensing services to several of the company's community pharmacies. People do not access the pharmacy as their dispensed medicines are sent to their chosen community pharmacy.

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 suitably identifies and manages the risks associated with its services. It has written procedures that the pharmacy team follows. And it completes all the records it needs to by law. The team protects people's private information correctly and responds well to people's concerns. Team members respond appropriately when errors occur. They discuss what happened and they take action to prevent future mistakes.

Inspector's evidence

The offsite hub dispensing service was provided to several pharmacies, also known as spoke pharmacies, within the company. The number of pharmacies accessing the service had gradually increased over several months with a maximum of two new pharmacies brought into the service each week. This enabled the teams at the hub and at the spoke pharmacy to identify any issues. Each pharmacy was assessed for its suitability to use the service by an area manager who liaised with the team at the spoke pharmacy.

The pharmacy had a range of up-to-date standard operating procedures (SOPs) to help pharmacy team members manage the risks associated with the services offered. Team members accessed the procedures via the pharmacy's electronic human resources system. And they had signed the SOP signature sheets to show they understood and would follow the SOPs. They demonstrated a clear understanding of their responsibilities and worked within the scope of their role. Each spoke pharmacy had a dedicated set of SOPs covering the processes for sending prescriptions to the hub. This formed part of the introduction pack sent to the team at the spoke pharmacy before it began using the offsite dispensing services.

The pharmacy had comprehensively identified and considered the risks of delivering its services to people and the spoke pharmacies. The superintendent pharmacist (SI) and operations director along with other pharmacy team members had implemented several actions to mitigate these risks. For example, the use of advanced automated technology to manage the large volumes of prescriptions dispensed. But also using manual checks to ensure prescriptions were safely dispensed. Prescriptions dispensed by the pharmacy's robotic technology were subject to quality and safety assurance checks periodically by a pharmacist. For spoke pharmacies new to the service 100% of the prescriptions submitted were checked by the pharmacist in the first week of integrating with the hub. After the first week the pharmacist checked a representative sample of prescriptions, based on the volume of dispensing being undertaken for each spoke pharmacy. Records of these risk assessments and the actions taken were limited. So, team members didn't have all the information available to refer to and manage emerging risks on an ongoing basis. Senior managers analysed data from their systems every two weeks at a Quality Development Meeting to help identify issues and trends that needed to be addressed.

Each workstation had a near miss log, that team members used to record their errors. The information collected was discussed with the team member at the time of the incident. And the lead pharmacist analysed the data each month to identify patterns. Investigations of near miss errors involved access to a range of systems and documents including the pharmacy's CCTV which was placed the workstations. Near miss errors were discussed at the Quality Development Meetings where senior managers

identified actions to help prevent the same or similar errors happening again. When the actions involved amendments to the automated technology team members tested the changes in a secure test environment. This helped to make sure the changes were safe and correct, before introducing them on a larger scale to the pharmacy's 'live' environment.

As part of the preparation for using the hub, the team at the spoke pharmacy spent time with people explaining the process and the timescale for ordering their repeat prescriptions. This followed feedback from some spoke pharmacies that people were concerned their repeat prescriptions were not available on the same day they were generated, as had previously been the case. When the prescription data was received by the hub, the person was sent a text message advising them it was being prepared. Followed by a further text message advising when the prescription would be ready to collect, to help keep them informed and manage their expectations.

The pharmacy had current indemnity insurance. The correct Responsible Pharmacist (RP) notice was displayed, and the RP log was properly maintained. Each workstation had a dedicated bin, which was clearly marked and used to collect confidential waste. The pharmacy had documented data protection procedures in place. Team members completed annual training on data protection and cyber security, including completing the NHS data protection toolkit. Team members had up-to-date training, relevant to their roles, on identifying and managing safeguarding concerns.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. It recognises the importance of ensuring all team members working with the automated dispensing systems understand their role in the safe dispensing of prescriptions. And it provides appropriate training to support this. Team members work well together, and they are good at supporting each other in their day-to-day work. But they have limited opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist covered the operating hours of the pharmacy with support from the SI, the chief executive officer and the operations director who were pharmacists. The pharmacist had completed an induction programme after recently joining the pharmacy. This included visiting some spoke pharmacies that used the offsite dispensing services of the hub to observe the process from the spoke pharmacy's perspective. A full-time dispenser worked alongside the SI and the operations director in a training role to support the spoke pharmacies as they went live with the offsite dispensing service. The pharmacy team was supported by a purchasing team and a team member who took queries from the spoke pharmacies.

All team members who handled medicines during their daily work were qualified dispensers or enrolled on a dispenser training course. This ensured all team members involved in every stage of preparing and dispensing of prescriptions had a good understanding of their responsibilities. This included team members who had roles such as adding stock to the automated picking system, to help them understand how their role supported the safe dispensing of prescriptions. Some team members were training to become pharmacy technicians and accuracy checking technicians to support the pharmacist. All trainees had protected time at work to complete their training and were supported by experienced team members. Plans were in place for the full-time engineers on site who maintained the automated systems to complete similar training. They were supported by an area manager from the company providing the automated technology who had experience in similar pharmacy operations. Team members held regular meetings and received informal feedback on their performance. The pharmacy did not ask team members to meet any performance related targets. Plans were in place to implement a programme of ongoing learning for pharmacy team members.

The pharmacy provided a range of support to the spoke pharmacy as it moved to the hub's offsite dispensing service. Several weeks before using the hub, the spoke pharmacy received a 'go-live' pack, containing key information, SOPs and training for pharmacy team members about the hub system. This included a set of frequently asked questions developed from learning and feedback from spoke pharmacies that were using the hub. After going live, team members at the spoke pharmacy were supported for a few days by the trainer who was present at the pharmacy. And they provided team members with training and one-to-one advice. This included sending a few prescriptions to the hub that the trainer collected and returned to the spoke pharmacy to show the team how to book-in the dispensed prescriptions. The spoke pharmacy also received weekly calls from the trainer and other team members at the hub to discuss any issues and provide them with an opportunity to ask questions. When required, the trainer provided refresher training to the team at the spoke pharmacy. Regular meetings with all spoke pharmacies took place and feedback from these teams was sought. The SI

regularly visited all the pharmacies so team members could speak to her directly.

Principle 3 - Premises ✓ Standards met

Summary findings

The 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 warehouse facility. This provided plenty of space for team members to work and for storing stock. Team members kept the areas clean and tidy. They kept floor spaces clear to prevent trip hazards and they followed health and safety procedures for the automated parts of the process to keep themselves safe. 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 manages its services well. It uses automation to support the safe delivery of its dispensing service to ensure people receive their medicines when they need them. It reviews its systems and processes and suitably acts to ensure the delivery of its services remain safe and efficient. The pharmacy gets its medicines from reputable sources and it ensures medicines are fit for purpose and are suitable to supply.

Inspector's evidence

The offsite dispensing service provided by the hub pharmacy was limited to repeat prescriptions. Urgent prescriptions, along with prescriptions for controlled drugs and people requiring their medicines in multi-compartment compliance packs, were dispensed locally at the spoke pharmacy. New spoke pharmacies had a list of medicines usually dispensed by the hub pharmacy so the team at the spoke pharmacy knew what the hub could usually provide. The electronic patient medication records (PMR) system at each spoke pharmacy was integrated with the hub's electronic system. This meant team members at the spoke pharmacy could track prescriptions at each stage of the dispensing process. And could easily identify any issues that may cause a delay to the dispensing of the prescription. Spoke pharmacies also had the option to retrieve a submitted prescription to dispense locally if required. Prescriptions were labelled and clinically checked by the pharmacist at the spoke pharmacy before details from the prescriptions were sent to the hub pharmacy. Prescriptions received at the hub by 3pm were generally dispensed and returned to the spoke by 12pm the following day.

The pharmacy used an automated system for picking most of the prescribed items. Items such as liquids and large tubs of creams were stored in areas where team members manually picked them. Team members used bar code technology to ensure the picked medicines matched the prescription data before the medicines were placed into an automated labelling system. They ensured the medicines were correctly positioned to make sure the labels were attached to the correct places on the packaging. Throughout the automated dispensing process, various measures and steps were completed to ensure the correct medicine was dispensed. These included scanning the barcodes to make sure the medicine matched what had been prescribed. And optical recognition cameras that detected the information printed on the medicine packs and labels, to ensure it matched the electronic data on the prescription. Each dispensing label contained a barcode which the system scanned to confirm the accuracy of the information printed on the label. If the system found an anomaly at any stage in the process, the dispensed medicine was flagged and segregated via a dedicated chute. This was then passed to a team member to check and resolve. Labelled medicines for each prescription were placed on an individual conveyor. And only one person's prescription was permitted on a conveyor at a time, to help prevent prescriptions being mixed up.

Completed prescriptions were sealed in compostable bags at the final stage of the automated process. Barcodes and optical scanning were used as a final accuracy check before the bags were placed in a sealed tote box to send to the spoke pharmacy. The pharmacy used a courier to deliver the dispensed medicines to the spoke pharmacies. When required, the delivery drivers from the spoke pharmacy also collected the dispensed medicines from the hub. The pharmacy used barcodes and geo-location technology to track each tote leaving the hub and arriving at the spoke pharmacy. The geo-location technology meant that the courier was unable to scan and accept, or scan and deliver, totes that were

geo-tagged for a different location. This helped to prevent a courier from collecting the incorrect totes from the hub and delivering totes to the incorrect pharmacy. The senior pharmacy team had a close working relationship with the courier. This meant they were able to quickly highlight and resolve delivery issues and make sure medicines arrived at the spoke pharmacies on time. For example, on one occasion the courier driver had left the tote at the medical centre attached to the pharmacy. This was immediately alerted to the courier who responded promptly and reminded their delivery drivers of the importance of making correct deliveries. The booking-in process at the spoke pharmacy triggered text messages to be sent to people advising their prescriptions were ready to collect.

When a medicine was received at the pharmacy from a wholesaler for the first time, it underwent a product setup process on to the pharmacy's electronic system. This process was always conducted by a pharmacist who checked all the particulars of the medicine and entered them on to the system. The information recorded included the name, strength, quantity, and brand of a medicine. And included capturing the barcodes embedded on each manufacturer's pack. The dimensions of the packaging, and a photograph used for optical recognition in the dispensing process were also captured. Scanning the barcodes on the packaging enabled the batch number and expiry date to be recorded. And this information was used to highlight and remove medicines three months before their expiry dates and when the medicine was subject to a manufacturer's recall. The system also identified if the medicine held the same barcode as one already in the system, to help prevent selection errors. Once the setup process was complete the information entered was checked by a second pharmacist to ensure it was accurate before it was released. New products were automatically flagged for a manual check by a pharmacist at the end of the dispensing process, to ensure the automated system had accurately dispensed the medicine. The pharmacy also applied this manual quality assurance check whenever a different brand of the same medicine was supplied. Any products that were too small to fit the automation process were highlighted to the purchasing team to ensure that brand was not ordered again.

When a medicine was not available at the hub, the missing item was ordered. And the dispensing of all the other prescribed medicines was held for up to 48-hours so all the medicines could be sent together. If the ordered medicine had not arrived after this time the remaining medicines were dispensed, or the prescription was returned to the spoke pharmacy to dispense locally. The spoke pharmacy could see prescriptions on hold and the reason, for example awaiting stock. The pharmacy had processes to manage medicine stock shortages. Team members at the spoke pharmacies were alerted to long term availability issues with a medicine when they entered the prescription data to send to the hub. This meant they could see immediately if a medicine was not available for dispensing at the hub so it could be dispensed locally, or they could arrange for an alternative medicine to be prescribed. The purchasing team monitored stock shortages so alternative medicines could be obtained when required. And advised the pharmacy team of stock shortages and changes to suppliers. All the pharmacy professionals in the team received safety alerts or manufacturer's recalls, which the pharmacist responded to.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy uses technological 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's automated systems were serviced and maintained by two engineers who were seconded by the manufacturers to work full-time onsite at the pharmacy. The engineers conducted routine servicing of the equipment each week and were available to respond to technical difficulties immediately. The systems manufacturer also provided technical IT support. The level of response to issues was graded according to severity, and the response times were graded accordingly, from half an hour to four hours. Team members documented each issue that occurred and fed this information back to the manufacturer as part of a monthly analysis of issues identified. This helped to establish patterns of occurrences. Senior members of the pharmacy team regularly met with the engineers and the manufacturer to provide feedback and discuss concerns.

The pharmacy computers were password protected and data was encrypted to ensure people's confidential information was protected. The data was stored in a cloud-based system which was regularly backed-up. The pharmacy had systems in place to support team members health and safety at work including clearly marked first aid points that included a defibrillator.

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.