General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP Oakwood, Oak Drive, Featherstone, WOLVERHAMPTON, WV10 7QD

Pharmacy reference: 1109653

Type of pharmacy: Prison

Date of inspection: 26/05/2021

Pharmacy context

The pharmacy is located within HMP Oakwood category C male prison in the village of Featherstone, close to the town of Wolverhampton. It supplies the medicines for the prisoners of seven prisons. The pharmacy also supplies stock medicines to these prisons.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not identify and manage all the risks associated with delivering its services. The pharmacy is extremely busy and low staffing levels and external pressures are cited as contributory factors in recent recorded errors.
		1.2	Standard not met	The pharmacy team members sometimes do not follow their written procedures which leads to mistakes.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough staff to manage its large workload safely. Staffing levels have been cited as factors in recent errors.
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 not all met**

Summary findings

The pharmacy does not identify and manage all the risks associated with delivering its services. The pharmacy is extremely busy and low staffing levels and external pressures are cited as contributory factors in recent recorded errors. And because of these pressures, the team members sometimes do not follow their written procedures which also leads to mistakes. The team members record few mistakes considering the large volume of dispensing at the pharmacy. And they do not identify specific actions to prevent these from happening again in the mistakes that are recorded. The pharmacy is appropriately insured to protect people if things go wrong. It keeps the required up-to-date records. The team members keep people's private information safe.

Inspector's evidence

This inspection took place during the COVID-19 pandemic. The pharmacy supplied both named patient and stock medicines to seven prisons. The pharmacy team members identified and managed some risks associated with providing its services. But it was extremely busy and the team had little time to do anything other than dispensing. And there had been recent changes to staffing (see further under principle 2). As a result of the COVID-19 pandemic, the door to the pharmacy was locked to reduce the risk of transmission of coronavirus. Any nurses or other people had to knock in order to access the pharmacy. No prisoners came to the pharmacy. The team members worked back-to-back and not side-by-side to reduce transmission of COVID-19. All the staff wore type 2R fluid resistant masks.

The team members had completed occupational risk assessments because of COVID-19. But these had not been reviewed since they were originally done some time ago. The team members knew that they needed to report any COVID-19 positive test results. They had received both doses of a COVID-19 vaccine.

The pharmacy team members recorded their own near miss mistakes, that is, mistakes that were detected before they had left the premises. However, the number of near miss errors recorded were very low considering the volume of dispensing carried out. For example, in the samples seen, two or three errors per person were recorded each month for the last three months. Several of the error records seen stated rushing to meet deadlines, being short-staffed due to absences and being under pressure as causes for making the errors. A pharmacy team member admitted that not all near miss errors were recorded, particularly if team members were busy or under pressure, which was often the case. The accuracy checking technician (ACT) analysed the near miss errors recorded to look for patterns. And they recorded their analysis to feed back to the team. The records seen over approximately the last six months stated patterns of errors being caused by various staffing issues, rushing to complete work and meet deadlines and interruptions or distractions. But other than discussing the issues with the team, little else was done to prevent the patterns occurring again.

There were very few documented dispensing errors where the wrong medicines left the pharmacy, considering the very large volume: 3 in 2021, 3 in 2020, 1 in 2019. Two examples of incident reports were seen. One from 22 March 2021 was for an incorrect quantity of Eplerenone where the prisoner was provided with less than prescribed. The causes recorded were being understaffed due to staff sickness and holidays and only having one pharmacist. The pack of Eplerenone was not marked as a

split box and staff did not use the tick method to check their work. A second example was from 26 November 2020 where a prisoner was provided with a part supply of Haloperidol 500 microgram tablets correctly. However, when the owing was supplied, they were provided with 5 milligram tablets. The cause of the error was stated as the pharmacy being understaffed due to staff sickness.

Two pharmacy team members independently explained that they often found themselves cutting corners and performing tasks other than in accordance with Standard Operating Procedures (SOPs) to help save time. One example was not performing the tick method when checking their work. Or when re-issuing medicines from a previous occasion, using the patient medication record, not carefully checking that nothing had changed. Both of these were documented in near miss and incident reports as reasons for errors occurring.

The dispensary was small considering the workload at the pharmacy. The staff used different coloured baskets for the different prisons. But many baskets were seen piled on top of one another both on the floor and on the assembly benches. This increased the likelihood of errors.

The pharmacy had current public liability and indemnity insurance provided by the National Pharmacy Association (NPA). It kept the required up-to-date records: the responsible pharmacist (RP) log, controlled drug (CD) records and specials records. The pharmacy also had fridge temperature records, date checking records, patient-returned CD records and cleaning rotas.

The staff understood the importance of keeping people's private information safe. They stored all confidential information securely. The pharmacy team members shredded all confidential wastepaper. The pharmacy team understood safeguarding issues. The pharmacists and ACT had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. But the pharmacy team members had not done any specialist learning on safeguarding bearing in mind that all their patients were potentially vulnerable.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not have enough staff to manage its large workload safely. Staffing levels have been cited as factors in recent errors. And the pharmacy receives no additional help when staff are ill or on holiday. The team members do some regular learning but this is not specific to their roles in the prison.

Inspector's evidence

The pharmacy was very busy. It was located within HMP Oakwood in the village of Featherstone, close to the town of Wolverhampton. The pharmacy only supplied medicines for the prisoners of seven prisons. Several of these patients received their medicines in multi-compartment compliance aids. The current staffing profile was two full-time pharmacists (both newly appointed), one full-time ACT, one part-time NVQ3 qualified technician and five full-time NVQ2 qualified dispensers (one of whom was the newly appointed manager). The pharmacy had no procedures to accommodate either planned or unplanned staff absences. The part-time technician tried to cover as many hours as she could but she had child-care commitments. A part-time dispenser had left in February 2021 and had not been replaced. A technician was on long-term leave and just one day of her hours had been replaced.

The ACT explained that she rarely had time to act as such. She was only able to check approximately 2 to 3% of the prescription volume because she was required to do tasks such as dispensing and other housekeeping. This meant that she may become de-skilled. It also meant that the pharmacist undertook most of the accuracy checking and so had little time for interventions and counselling (see under principle 4).

The pharmacy team members explained they were often unsure where to raise queries and concerns, both in the prison and internally within the company.

The pharmacy team members completed approximately 30 minutes of training per month. But this was community pharmacy orientated and not specific to their roles in a prison environment. The pharmacists and ACT recorded any learning on their continuing professional development (CPD) records. The team members had an annual appraisal. The pharmacy was not subject to any targets or incentives.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is small for the services it offers. It is untidy which does not look professional and this also increases the risk of mistakes. But this should be resolved if the staffing levels are addressed. The premises are thoroughly cleaned to reduce the likelihood of transmission of coronavirus.

Inspector's evidence

The premises was small for the workload. There were dedicated work areas: three assembly benches and a checking bench. But due to the workload, there were many baskets piled on top of one another both on the floor and on the benches. This did not present a professional image. And it increased the risk of errors.

The premises were clean. As a result of COVID, the pharmacy was cleaned three times day. Frequent touch points were and the dispensary benches were cleaned throughout the day. The pharmacy team members washed their hands regularly throughout the day.

The temperature in the pharmacy was below 25 degrees Celsius and it was well lit. No prisoners presented at the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy gets its medicines from appropriate sources and stores them safely. But the pharmacists could have more direct contact both with the prisons and with the prisoners to make sure that the medicines prescribed are appropriate and that the prisoners are given the right advice and support.

Inspector's evidence

No prisoners came to the pharmacy. There was no pharmacy input into any clinics at HMP Oakwood which was on the same site as the pharmacy. The pharmacist did not discuss medicines with any prisoners. Pharmacy staff were not involved in any issues in the wings at Oakwood including stock reconciliation. The pharmacy team did not routinely check the risk assessments for prisoners who had their medicines in-possession to ensure that they were appropriate, reviewed and up to date. Risk assessments were not always reviewed by doctors when a new medicine was added.

The pharmacy team members did check that the medicines prescribed were on the prisons drug formulary but several medicines were given at times that did not comply with recommended dosage schedules. And so, these may not be optimally effective. There was no pharmacy input into the hesitancy of some prisoners to have the COVID-19 vaccination. As mentioned under principle 2, the staffing issue at the pharmacy did not allow the pharmacists to perform these valuable functions.

The dispensary team members assembled medicines into multi-compartment compliance packs for many prisoners across the seven prison it provided services to. The provided patient information leaflets each month. The pharmacy only labelled the outer containers of insulin to prisoners. Loose unlabelled insulin pens were seen on two wings at HMP Oakwood. This posed a patient safety risk. The pharmacy labelled the innermost containers of other medicines, such as inhalers and creams. There was a good audit trail for all items dispensed by the pharmacy.

The pharmacy obtained its medicines and medical devices from AAH and Alliance Healthcare. Its controlled drugs (CDs) were stored tidily in accordance with the regulations and staff access to the cabinet was appropriate. The pharmacy used designated bins for medicine waste. And it separated any cytotoxic and cytostatic waste substances.

The pharmacy team members dealt with any concerns about medicines and medical devices. They received drug alerts electronically, printed them off and checked the stock. A folder was used to store the alerts. The team member who checked the medicines signed and dated the alert and included any required actions. There was also an electronic audit trail. The pharmacy had received a recent alert about itraconazole 10mg/ml solution. It had none of the affected batches in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has taken action to reduce the spread of coronavirus. It has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose.

Inspector's evidence

As a result of the pandemic, the pharmacy had a ‘closed-door’ policy to reduce the likelihood of transmission of COVID-19. All the staff wore Type 2R fluid resistant face masks. And they worked back-to-back rather than side-to-side.

The pharmacy used British Standard crown-stamped conical measures and ISO marked straight cylinders (10 - 100ml). It had tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. The pharmacy had up-to-date reference books, including the British National Formulary (BNF) 80 and the 2020/2021 Children’s BNF.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The staff shredded all confidential waste information.

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.