General Pharmaceutical Council

Registered pharmacy inspection report

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

Pharmacy reference: 1109653

Type of pharmacy: Prison / IRC

Date of inspection: 18/05/2022

Pharmacy context

The pharmacy is inside HMP Oakwood near Wolverhampton. Pharmacy team members dispense medicines to seven prisons across the West Midlands. And they provide some of these medicines to people in multi-compartment compliance packs. The inspection was completed during the Covid-19 pandemic.

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 adequately identifies and manages risks to its services. And it keeps the records it must by law. Pharmacy team members regularly record and discuss mistakes they make. They generally learn from these to reduce the risks of similar mistakes. And they reflect to establish whether their changes work and make the pharmacy safer. Team members understand their role to help protect vulnerable people. And they generally protect people's private information.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. It had reviewed the procedures in 2021. And had scheduled the next review of the procedures for 2023. Pharmacy team members had read the procedures since the review. And they had signed a declaration to confirm their understanding. The pharmacy manager explained that pharmacy team members would also be asked to read the procedures again if necessary after an incident in the pharmacy.

The pharmacist highlighted and recorded near miss errors made by pharmacy team members when dispensing. Team members discussed their mistakes with each other. This included discussion about why mistakes might have happened. And they used this information to make changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines, such as amlodipine and amitriptyline, to help prevent the wrong medicines being selected. Team members attached stickers to the shelves in front of these medicines to help draw people's attention to the risks when dispensing. And they highlighted prescriptions for common LASA medicines. They added a stamp to these prescriptions. And the dispenser and pharmacist signed the stamp to confirm they had checked that the correct medicine had been dispensed. The pharmacy manager analysed the data collected every month to look for patterns. And they discussed this with the team at a regular patient safety meeting. Pharmacy team members had identified a high volume of quantity errors being made. They had discussed that this may be due to the high volume of dispensing they completed each month. And because the quantities of medicines being prescribed to people in prison were often different to the quantities in whole packs. To help minimise these errors, they changed the way they dispensed prescriptions to help them to double check the quantities they had dispensed. This resulted in a small reduction in the number of quantity errors they made. But on reflection, they felt they could do more. So, they were in the process of implementing a quadrant stamp system. They intended to use the stamp to sign to confirm they had checked the quantities they had dispensed to confirm they were correct. Records of near miss errors were available. Pharmacy team members did not always capture much information about why the mistakes had been made or the changes to prevent a recurrence. Sometimes, pharmacy team members identified and rectified near miss errors they made before they reached the pharmacist. They explained these errors were discussed. But they were not recorded. So, pharmacy team members might miss some opportunities to learn and make changes to improve the pharmacy's services.

Pharmacy team members explained feedback from people was usually collected verbally. And the pharmacy manager also discussed feedback about the pharmacy and its services at regular medicines management meetings. These meetings included other people involved in managing healthcare in each prison. One recent piece of feedback had been a request for the pharmacy to provide a consignment document with each delivery of medicines. And this would help people at the receiving prison to check

they had received all the medicines they requested for people. Pharmacy team members were currently exploring ways to create an automated solution to help them do this without significantly impacting on their workload. Pharmacy team members regularly raised interventions about prescriptions with prescribers. And they documented their interventions so they could refer to them in the future. Some recent examples included queries about the doses of beclomethasone inhalers and Sofradex eye drops prescribed for people. The pharmacy manager also compiled a report of prescribing interventions each month. And they fed these back to the prison's medicines management team. And to the company's quality assurance meeting so information could be shared with other establishments nationally, as well as prisons locally.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. Pharmacy team members audited these against the physical stock quantity every week. The pharmacy kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And this was also complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily.

The pharmacy could only be accessed by authorised team members. It had a documented procedure available to help pharmacy team members properly destroy confidential waste. Pharmacy team members completed training about how to manage confidentiality and privacy every six months. And up-to-date records of their training was available. Pharmacy team members shredded some confidential waste. And the pharmacy had confidential waste bags available to collect confidential waste. These bags were collected for secure destruction. Pharmacy team members disposed of unwanted dispensing labels by covering sensitive information with a black marker pen. Or by sticking labels together so that when separated, the adhesive rendered the information unreadable. These were then placed in the general waste bin. But the inspector found some labels that could be separated without the sensitive information being destroyed. This was discussed. Pharmacy team members explained they had recently changed their label supplier. And they were unaware that the adhesive on the new labels was not as strong. They also discussed that they did not shred labels because the adhesive had caused damage to shredders. They gave their assurance that they would stop using this method to dispose of labels immediately. And they would use the confidential waste bags instead. Pharmacy team members also removed labels from the general waste bins during the inspection. Pharmacy team members gave some examples of how they would raise their concerns about vulnerable people. They explained how they would refer their concerns to the pharmacist or the head of healthcare at the person's prison. The pharmacy had a documented procedure explaining how team members should raise their concerns about vulnerable people. Pharmacy team members completed training via e-learning every six months. They explained the training was very comprehensive. But it was not tailored to the prison environment. And team members explained how they found it difficult to apply their training to the environment they worked in.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They feel comfortable raising concerns and discussing ways to improve services. And they are confident that the pharmacy listens to their views. They complete some appropriate, training to help keep their knowledge and skills up to date. But more could be done to make sure the training provided is relevant to their roles.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the responsible pharmacist, two pharmacy technicians, one of which was trained to carry out the final accuracy check of prescriptions (ACT), and four dispensers. The pharmacy manager explained that they were currently in the process of recruiting three more full-time dispensers to help manage the pharmacy's workload. And in the meantime, they were regularly using locum dispensers. The manager explained that the pharmacy still had some difficulties covering unplanned staff sickness absence. And this was due to the security clearances required for people to work in the prison pharmacy, which most locum staff did not have. They were confident that the current recruitment process would help to address this. And would help to provide some contingency planning to unplanned absences. The pharmacy was also currently revaluating the skill mix of the pharmacy team. This was to help make sure pharmacy team members skills were being fully utilised, for example by using ACTs to complete accuracy checks fully where possible. And by up skilling other pharmacy team members to manage the workload more efficiently.

Pharmacy team members completed regular mandatory online training modules. Recent examples included safeguarding and confidentiality. Pharmacy team members explained that the training modules rarely provided training specific to the prison hub pharmacy environment. They also discussed topics with the pharmacists and each other. A dispenser explained they would raise any specific learning needs verbally with the pharmacy manager or pharmacist. And they felt they would be supported by being signposted to relevant reference sources or by discussion to help address their learning needs. Pharmacy team members explained they did not usually have time at work to complete voluntary training. They hoped this would improve when more team members had been recruited.

Pharmacy team members explained how they would raise professional concerns with the pharmacy manager or the superintendent pharmacist. They felt comfortable raising concerns. And making suggestions to help improve the pharmacy. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. Pharmacy team members explained they felt more supported by their new managers since the pharmacy changed ownership in June 2021. And they were confident with the pharmacy's strategic progress. One example of a recent challenge raised to managers were the number of urgent prescriptions the team was being asked to process. The pharmacy was often receiving urgent prescriptions from all their prisons, many of which were arriving after 09.30. And the cut off for them to be able to deliver them the same day was 10.00. This was putting pharmacy team members under significant pressure to dispense prescriptions quickly. And this had occasionally contributed to them making mistakes. Team members had raised this with their regional quality manager. And the issue was currently being discussed at a higher level across the company to establish why prisons were ordering so many medicines on an urgent basis. And why prescriptions were not being planned better. The company was currently exploring the impact of better

medicines management across all seven prisons on the hub's dispensing workload. The pharmacy manager explained that since the work began, there had been a reduction in the number of urgent prescriptions the hub was receiving. They were hoping for more progress as discussions continued.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and properly maintained. It provides a suitable space for the services it provides.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy's floors and passageways were generally free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises.

There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a toilet nearby, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained heat and light to acceptable levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to the people who need them. It has systems in place to help provide its services safely and effectively. And it sources its medicines appropriately. Pharmacy team members regularly provide people with appropriate information about their medicines. And this includes for high-risk medicines.

Inspector's evidence

The pharmacy was inside the prison and it could not be accessed by prisoners or unauthorised staff. People were able to book an appointment to talk to someone about their medicines or health via an electronic booking system. Their request was triaged and allocated to the most appropriate member of the healthcare team. People's queries about medicines were referred to a pharmacist or pharmacy technician. They would book an appointment to see the person, usually the next day, to help them resolve their query.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. They highlighted prescriptions to alert the pharmacist to key information. This included for any new medicines for the person, changes to current medicines or whether the person was new to the pharmacy. Some people were able to manage their own medicines following a suitable risk assessment to establish whether they could safely manage their medicines "in-possession" (IP). The outcome of their IP risk assessment was documented on each prescription. And this helped pharmacy team members to establish how best to dispense their medicines. Pharmacy team members also highlighted prescriptions where a look-alike or sound-alike (LASA) medicine had been dispensed. This prompted both the dispenser and the pharmacist double check that the correct medicine had been selected from the shelves. And they signed the prescription to confirm the correct medicine had been dispensed. Medicines were picked from the shelves, labels printed, and medicines assembled for checking by three different people. The person generating the labels and the person assembling the prescription signed the prescriptions to maintain an audit trail of the people involved in the dispensing process. But the person who selected the medicines from the shelves was not captured in the adult trail. So, pharmacy team members might miss opportunities to learn from this person or make changes to improve if they made mistakes.

The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They would also check if they were on a pregnancy prevention programme. The pharmacy had information materials available to give to people to help them manage the risks safely. The pharmacy dispensed clozapine to people. The pharmacist explained that the person's latest blood test information was accessed online to make sure it was safe to supply clozapine to them. And they would raise an intervention with the prescriber if the blood test results were not within the expected safe range. The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines

each month. Pharmacy team members documented any changes to medicines provided in packs on the person's master record sheet and on their electronic records. The pharmacy routinely provided other prisoners with information leaflets about their medicines each month.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines neatly on shelves. It kept all stock in restricted areas of the premises where necessary. The pharmacy had disposal facilities available for unwanted medicines, including CDs. Pharmacy team members monitored the minimum and maximum temperatures in the fridge where medicines were stored each day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members checked medicine expiry dates every three months. And up-to-date records were seen. Pharmacy team members highlighted and recorded any short-dated items up to six months before their expiry. And they removed expiring items during the next date check or during the month before the product was due to expire.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment appropriately.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable equipment available to collect its confidential waste. It kept its computer terminals in the secure areas of the pharmacy. And these were password protected. The pharmacy's fridge was in good working order.

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.