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: 24/04/2024

Pharmacy context

This is a pharmacy situated inside HMP Oakwood near Featherstone, in Staffordshire. It is registered as a pharmacy to dispense prescriptions for people living in seven prison establishments across Staffordshire and West Midlands. The pharmacy is not open to the public and is separate to the healthcare team inside the prison.

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 has written procedures which are followed by the pharmacy team. And this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy keeps the records it needs to by law. And members of the team are given training so that they know how to keep private information safe. They review and discuss things that go wrong to help identify learning opportunities. But records of the reviews are not kept which would help to identify underlying themes.

Inspector's evidence

There was a set of standard operating procedures (SOPs), some of which were overdue their stated date of review in July 2023. So, they may not always reflect current practice. Members of the pharmacy team had signed training sheets to show they had read and accepted the SOPs.

The pharmacy had systems in place to record, investigate, and identify learning from dispensing errors. A paper log was used to record near miss incidents. And each month, the pharmacy manager discussed the near miss log as part of the team's monthly meeting. But the review only consisted of a visual check of the records with no written analysis or records made. So, the pharmacy may miss the opportunity to share some of the underlying causes of mistakes with its team members. To help reduce the risk of quantity errors, the team members had to initial the prescription which acted as a reminder to check the quantity before an accuracy check was completed.

The roles and responsibilities for members the pharmacy team were described in individual SOPs. A trainee dispenser was able to explain their role and what their responsibilities were. Members of the pharmacy team wore standard uniforms and had ID badges identifying their names and roles. The correct responsible pharmacist (RP) notice was on display. The pharmacy had a complaints procedure. Any complaints would be recorded and followed up by the pharmacy team. A current certificate of professional indemnity insurance was available.

Records for the RP and unlicensed specials appeared to be in order. Controlled drug (CD) registers were maintained with running balances recorded and frequently checked. Two random balances were checked and were found to be accurate. Returned CDs were recorded in a separate register.

An information governance (IG) policy was available, and members of the team had completed IG training. When questioned, a trainee dispenser was able to explain how confidential waste was separated and removed by a waste carrier. Safeguarding procedures were available, and members of the team had completed safeguarding training. A trainee dispenser was able to explain what types of concern they would raise within the prison's safeguarding process and knew who the safeguarding lead was.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough members of the team to manage the pharmacy's workload and they are appropriately trained for the jobs they complete. Members of the pharmacy team complete additional training to help them keep their knowledge up to date. They routinely identify improvements to the clinical prescribing of medicines and intervene when necessary. And they routinely attend team meetings with the prison's healthcare team which helps to improve patient care.

Inspector's evidence

The pharmacy team included three pharmacists, a pharmacy technician, who was also the manager, four dispensers, one of whom was a supervisor, and two trainee dispensers. All members of the pharmacy team were appropriately trained or on accredited training courses. The volume of work appeared to be well managed. Staffing levels were maintained by agency staff and a staggered holiday system.

Members of the pharmacy team had access to an e-learning training platform. Part of the training platform was an annual requirement to complete mandatory learning related to health and safety topics. Team members were also tasked with learning packages to help them to learn and develop. The team were allowed learning time to complete training. And records were kept showing what training the team had completed.

When questioned, team members felt comfortable raising clinical questions to the pharmacist. And they felt able to raise these with the prescribers if needed. A record of prescription interventions was kept for future reference and showed they were doing so on a regular basis. For example, the team had queried the dose of an inhaler, which had been prescribed as a daily dose instead of the usual twice a day dose. They also raised a query when the quantity did not match the dosing schedule to make sure that enough of the medicine was supplied.

Members of the pharmacy team were seen working well together and assisting one another with their work and queries. Each morning, they would discuss their workload. And they attended the healthcare team's daily huddle to discuss any specific queries. Appraisals were carried out every four to eight weeks by the pharmacy manager. Members of the team felt the appraisals were a good opportunity to receive feedback or raise any concerns they had about their work. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to their line manager. There were no targets in place for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was situated within a designated room in the healthcare centre, located inside the secure facility. It was clean and tidy, and appeared adequately maintained. Patient sensitive information was not visible to non-pharmacy team members. The temperature was controlled using electric heaters and lighting was sufficient. Team members had access to a kitchenette area and WC facilities. The overall appearance of the pharmacy was professional.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible by the intended users. And it manages and provides them safely. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But the pharmacy does not always complete or make a record of prescriptions that have received a clinical check before they are supplied. Which may increase the risk of them being supplied without professional oversight to ensure they are safe to use.

Inspector's evidence

The pharmacy was accessible by its intended service users. People could also to speak to members of the healthcare team when they received their medicines at medicine hatches in the house blocks at their resident prison. Any medicine queries were noted to be followed up. The pharmacy utilised the workflow pattern through each stage of the dispensing process, using different members of the team for each stage. A rota had been implemented to change people's role each day. Members of the pharmacy team initialled 'dispensed-by' and 'checked-by' boxes on labels to show who had been involved in the dispensing process. They also used a quadrant stamp which team members initialled to show who had picked the medicines, labelled the prescription, and checked the quantity of the medicines. They used baskets to separate individual patients' prescriptions to avoid items being mixed up.

Some medicines were dispensed in multi-compartment compliance packs. Before a person was started on a compliance pack the prison healthcare team completed an assessment about their suitability. A record sheet was kept for each patient, containing details about their current medication. Any medication changes would be confirmed before the record sheet was updated. Disposable equipment was used to provide the service, and the compliance packs were labelled with medication descriptions. Patient information leaflets (PILs) were routinely supplied.

Any high-risk medicines (such as clozapine, warfarin, lithium, and methotrexate) were highlighted on the prescription and referred to the pharmacist for a clinical check. This also included any new medicines which were also highlighted on the prescription for the pharmacist to complete a clinical check. Any medicines which were not highlighted could be checked by a non-pharmacist accuracy checker. But as there was no process to routinely complete a clinical check or keep a record of when it was completed. This meant there was a risk that some medicines may be supplied without appropriate clinical oversight. The pharmacist had access to the clinical system which allowed them to view blood results and clinical notes. But this was done infrequently, and records of when it was used were not made. So, there may be a lack of care continuity. Members of the team were aware of the risks associated with the use of valproate-containing medicines during pregnancy. The team had identified one person at risk and ensured they understood the associated risks. And education material was supplied to the person alongside their medicine each time.

Medicines were stored in a secure box when they were transported to other establishments using a contracted service. The box was sealed, security tagged, and records of deliveries were kept with signatures.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from

a specials manufacturer if necessary. A process to check the expiry dates of medicines was in place. Team members usually signed a record sheet this had been completed. But the team had forgotten to record the last date check. Short-dated stock was highlighted using a sticker and liquid medication had the date of opening written on. Controlled drugs were stored appropriately in the CD cabinet, with clear separation between current stock, patient returns and out of date stock. There was a clean medicines fridge with a thermometer. The minimum and maximum temperature was being recorded daily and records showed they had remained within the required range. Patient returned medication was disposed of in designated bins. Drug alerts were received by email from the MHRA. Alerts were printed, with details of any action taken, when and by whom written on for future reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

Team members had access to the internet for general information. This included access to the British National Formulary (BNF), BNFc, and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had counting triangles for counting loose tablets. Equipment was kept clean.

Computers were password protected. A cordless phone was available in the pharmacy which allowed team members to move to a private area if the phone call warranted privacy.

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.