General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP Belmarsh, Western Way, Thamesmead, LONDON, SE28 0EB

Pharmacy reference: 1119009

Type of pharmacy: Prison / IRC

Date of inspection: 12/06/2024

Pharmacy context

The pharmacy is inside HMP Belmarsh. It provides services to the prison including dispensing prescriptions and administering medicines on the wings to patients. The pharmacy team provides additional services such as medicine reconciliation. The pharmacy also has appropriate authority to supply medicines including controlled drugs as stock to other healthcare services within 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

Overall, the pharmacy identifies and manages the risks associated with the provision of its services. Its team members have identified roles and accountabilities. They support and assist vulnerable people. The pharmacy deals with its mistakes responsibly. But because it does not record all the information it could, team members may be missing some learning opportunities to make things safer.

Inspector's evidence

The pharmacy had up-to-date processes in place to identify and manage the risks associated with its services. The pharmacy had a set of standard operating procedures (SOPs) and local operating procedures (LOPs) which were specific to the prison. They provided guidance to the pharmacy team about how to carry out their tasks safely. Not all the SOPs had been signed by all the staff to show they had read and understood them. But the pharmacy team members spoken to were able to explain their roles and responsibilities. Pharmacy technicians were able to explain what their responsibilities were, both in the pharmacy and when providing services in the treatment rooms on the wings. Members of the team wore standard uniforms and had badges identifying their names and roles.

The pharmacy had processes for learning from dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes where they had reached the person (errors). Near misses were discussed with the member of staff at the time and were then recorded in the near miss log. But the near miss log did not always have clear initial learning points and comments which might mean that it was harder to draw learning points from the records. The pharmacist reviewed the near miss log and discussed the review with the team at their weekly huddle.

The pharmacy had audit trails to support the safe delivery of its dispensing services. Prescriptions were printed off from SystmOne and signed by a prescriber before they were dispensed. The clinical check by the pharmacist was recorded on SystmOne. The final check for accuracy was by the responsible pharmacist (RP) or an accuracy checking technician (ACT).

The RP notice was visible at the time of inspection but displayed the name of the previous RP. The pharmacist changed the notice to display the correct RP. The pharmacy mainly maintained the necessary records to support the safe delivery of pharmacy services. The entries for two controlled drugs (CDs) in the CD register checked at random during the inspection agreed with the physical stock held. Balance checks were mainly completed monthly. When the CD register was checked there were two entries for CDs in the register recording that they had been supplied; but the CDs were still in the CD cupboard. The pharmacist said that this was not the correct process and that he would speak to the team. Patient-returned CDs were recorded in a designated register.

The pharmacy had appropriate professional indemnity insurance. Staff had been trained about data protection. The pharmacy had a policy about information governance. Confidential waste was disposed of appropriately. The pharmacy's dispensing system and SystmOne were password protected. The team used their own smart cards to access medication records, which could only be accessed by authorised personnel.

The pharmacy team had a good understanding of safeguarding requirements. The pharmacy

technicians had a clear understanding of what to do if vulnerable people on the house block did not attend for critical medicines. But records showed people did not always attend the houseblock for their medicines. The pharmacist said this was mainly to do with security issues within the prison.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the pharmacy's workload. Team members can raise concerns if needed.

Inspector's evidence

During the inspection, the pharmacy team managed the day-to-day workload of the pharmacy effectively. At the time of the inspection, there were two pharmacists present. There were eight pharmacy technicians and two pharmacy assistants. The pharmacy technicians were mainly based in the treatment rooms on the houseblocks.

One of the pharmacists was an independent prescriber. When necessary, he wrote prescriptions for people leaving the prison to make sure that they had medicines when they were released. But his prescribing skills were not being fully utilised by the healthcare team.

The team had access to e-learning for ongoing training. Some of the training was mandatory and its completion was monitored. This included topics such as data protection, safeguarding and basic life support. Informal training was provided as required. Staff had a yearly appraisal and also had regular meetings with their line manager. When asked, staff explained how they felt supported and were able to give feedback and discuss issues, for example at the weekly huddle.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. And people visiting the pharmacy can have a conversation with a team member in private.

Inspector's evidence

The pharmacy was in the healthcare block of the prison. It was a reasonable size for the workload. There was suitable heating and lighting, and hot and cold running water was available. Hand sanitiser was available. The premises were secure against unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. The pharmacy gets its medicines and medical devices from reputable sources and stores them safely. And it takes the right actions if any medicines or devices are not safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy premises was inside the prison, and it could not be accessed by prisoners or unauthorised staff. The pharmacy mainly used a dispensing audit trail which included use of 'dispensed by' and 'checked by boxes' on the medicine label. This helped identify who had completed each task. But some medicine labels on dispensed medicines were seen where either the 'dispensed by' or the 'checked by box' had not been initialled. The pharmacist said that he would remind the team of the need to sign the boxes to create an audit trail. The pharmacist who completed the clinical check was recorded on SystmOne which created an additional record. The team used trays to keep prescriptions and medicines for different people separate to reduce the risk of error.

The pharmacist performed a clinical check of all prescribed medicines. This included checking for any high-risk medicines (such as warfarin, lithium, and methotrexate) and checking the latest blood results were appropriate. And making sure that medicines were prescribed in accordance with the prison formulary. When the pharmacist wanted to give the person advice, he spoke to the pharmacy technician working on the house block the person was on and told them the advice that should be given. The pharmacy had a secure process to transport medicines to the treatment rooms on the house blocks.

Some people attended the treatment room to receive their medicines at an appropriate time. Other people were allowed to take away and keep either 7 days or 28 days of their own medicines (in-possession medicines). In-possession medicines are medicines that the prison has decided are safe for some people to hold and take themselves. The pharmacy technicians were responsible for most of the administration and management of medicines on the wing. They gave advice to people at the medicine's hatches. And in the contact seen they treated people professionally and with respect. The pharmacy did not have a minor ailments policy which meant it was more difficult for people to get medicines for minor self-limiting conditions. When a person came into the prison, pharmacy technicians checked that people were getting all the medicines they had previously been taking. But this was not always completed as quickly as it could be which meant that some people might have a delay in getting all their medicines.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacy technicians were responsible for managing medicines in the pharmacy and in the treatment rooms on the wings. Medicines were managed appropriately. The team date-checked medicines for expiry regularly and kept records of when this had happened. Short-dated medicines were identified by a sticker. The pharmacy received drug alerts by email and took appropriate action to keep people safe. The pharmacy kept suitable records to show this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had access to up-to-date reference sources. Records showed that the fridges were in working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy's portable electronic appliances had been tested in November 2023 to make sure they were safe.

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.