General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP Rochester Pharmacy, Oxleas NHS Foundation Trust, 1 Fort Road, ROCHESTER, Kent, ME1 3QS

Pharmacy reference: 1122587

Type of pharmacy: Prison / IRC

Date of inspection: 13/10/2021

Pharmacy context

The pharmacy provides services to HMPs Rochester, Elmlea, Swaleside, Stamford Hill, Maidstone, East Sutton Park and Cookham Wood. This includes the dispensing of medicines and the administration of medicines on the wings in HMP Rochester and provision of patient named medicines, and wholesale stock to the other prisons. The pharmacy also has a wholesale dealers licence and appropriate Home Office licenses to supply stock medicines including controlled drugs to the healthcare services to the other prisons. The inspection was undertaken during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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. It securely manages people's personal information. The pharmacy has some processes for learning from mistakes. But because it doesn't always record its near misses or their reviews, it could be missing opportunities to learn from them and to improve its services. It does not always record incidents, and this could make it harder to identify how to prevent a recurrence.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs) which reflected the nature of the pharmacy's activities. Members of the pharmacy team had a good understanding of their roles both in the pharmacy and on the prison wings.

The pharmacy kept some records of near misses, where a dispensing mistake had been identified before the medicine was handed out. And dispensing errors, where a mistake had happened, and the medicine had been handed out. Near misses were returned to the member of staff and they were told of their mistake and the aim was to record them in the near miss log. The pharmacy manager said that sometimes near misses weren't recorded. There was an informal review of the near miss log, but records of the review weren't made. The pharmacy team members said they would start discussing near misses at the regular team meetings. Dispensing errors were recorded on the 'Datix' system. Incidents that happened when nursing staff were in charge of the administration, but which were discovered by the pharmacy team, were not recorded on Datix by either team. This made it harder to ensure that learning occurred. The incident would be reported at the handover meeting, but follow-up was not guaranteed which would have happened if the incident had been recorded.

The pharmacy displayed the responsible pharmacist (RP) notice where it could be seen easily. The RP record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice when they were unsure of an issue. The pharmacy had current professional indemnity insurance arrangements in place, and this was arranged centrally.

The pharmacy mainly had the records needed to support the safe delivery of pharmacy services. These included RP logs, controlled drug (CD) registers, and records on the electronic prescribing and administration system. The CD registers in the pharmacy complied with legal requirements. CD Stock was audited regularly. There was a range of appropriate healthcare information on the wings.

Confidential paper waste was bagged and shredded in the prison. Confidential material kept on SystmOne, could only be accessed by smartcard with varied permissions dependent on the user's need or the medication record system. The pharmacy had an information governance protocol. Staff had received trained about the General Data Protection Regulation (GDPR).

All staff had completed safeguarding training; this was considered mandatory. Staff explained how they went and spoke to people who didn't come to the treatment room on the wing to take their medicine. But the follow-up procedure did not reflect what was in the SOP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a sufficient number of team members and they are suitably qualified and skilled for the services they provide. The pharmacy supports its team members in their development and provides a range of training to them. Team members work well together, and they can raise concerns if needed.

Inspector's evidence

During the inspection there were six pharmacists, eight pharmacy technicians and three trained dispensers present. Some of the pharmacy technicians spent most of their time outside of the pharmacy providing services such as administering medicines on the wings and there were four vacancies for these roles. The technicians had undergone additional training to ensure their competence in that role. Staff worked well together and engaged in the inspection process.

Staff were supported in developing their roles. The pharmacist was an independent prescriber. The pharmacy manager supported the technicians who administered medicines to the prisoners, which was a new role. In order to prevent them becoming de-skilled, and to maintain their accuracy checking technician qualifications they were going to spend one day a month working in the dispensary. They had monthly support one-to-one meetings with the dispensary manager. There was a wide range of online training available. The pharmacy team also had regular clinical training.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises secure from unauthorised access during working hours and when closed. And it largely maintains them appropriately. The premises protect people's confidentiality.

Inspector's evidence

The pharmacy was situated in the old healthcare block of the prison. And the pharmacy was kept secure. The premises were a reasonable size for the volume of work undertaken, but were in a poor decorative state. The room which housed the robot did not have any windows, but was air-conditioned. The temperature was suitable for medicines storage. There were clear workflows in place. Only members of staff accessed the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. The pharmacy gets its medicines from reputable sources and mainly stores them safely. It takes the right actions if any medicines are not safe to use to protect people’s health and wellbeing.

Inspector's evidence

There was no direct patient access to the pharmacy, but people could speak with a pharmacy technician on the wings during administration.

A dispensing audit trail was present to identify who had dispensed and checked each item. The pharmacy also used trays to ensure that prescription items were kept together which reduced the risk of error. Medicines were provided either in the manufacturer's packs, packed down into four seven-day supplies or put into plastic sealed pouches for daily supply to the patient. These pouches would either be given to the patient to take away, or the patient would be observed taking the contents. They were produced by a robot dispensing machine.

The robot was filled with containers, each with a different medicine in. Each container had loose tablets or capsules which had to be popped out from the manufacturer's packaging. There was a barcode scanner which confirmed the content of the container. The pharmacy sometimes popped out the medicines required in advance of having a container to put them in. This meant that they were left in a clear plastic bag containing the medicines and one of the packages from which they had been obtained. The pharmacist said that these would only be left like this for a day or so, but it was observed that some had been popped out over a fortnight before the inspection. The medicines for each person would be sealed into pouches, one for each time of day that the person should take them. Each pouch was labelled with the person's name, and the medicine names, forms and strengths which it contained. The roll of pouches would be put into a white box which was labelled with the usual label for dispensed medicines.

As well as providing standard pharmacy services around the dispensing against prescriptions, the pharmacy team provided wider services within the healthcare team. The pharmacy technicians had responsibility for medicine management, administration of medicines, and giving medicines for minor ailments on the wings. The pharmacy technicians gave advice on the wings about a range of matters including on new medicines and how to take antibiotics. Communications between the wider healthcare team was difficult due to the separation of the two healthcare units. Although the pharmacist and healthcare manager worked well together the involvement between the teams could be improved.

People taking higher-risk medicines were monitored and the clinical record was checked to ensure that the correct blood monitoring had been undertaken. A recent audit of people taking lithium had shown that people were being monitored, and that the pharmacy had checked that they were.

Pharmacy technicians provided medicine management on the wings. This included areas such as monitoring fridge temperatures, date checking, returning out-of-date and discontinued medicines to the pharmacy and keeping named-patient and stock medicines neat and tidy. The pharmacy got its

medicines from licensed wholesalers and stored them on shelves in a tidy way. There were coloured dots on the shelves and boxes to indicate items which were short dated. Regular date checking was done, and no out-of-date medicines were found on the shelves. The fridge temperatures recorded showed that the medicines in the fridge had been consistently stored within the recommended range. CDs were stored securely. Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to prisoners.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services it offers. It maintains its equipment and facilities adequately.

Inspector's evidence

The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets. Electrical equipment was regularly tested. Stickers were affixed to various electronic equipment and displayed the next date of testing.

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.