General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP Pentonville, Caledonian Road, Pentonville, LONDON, N7 8TT

Pharmacy reference: 1123346

Type of pharmacy: Prison / IRC

Date of inspection: 12/04/2023

Pharmacy context

The pharmacy is inside HMP Pentonville, a 'local' category B male prison. The pharmacy supplies individually labelled medicines to the prison wings for people to take as in-possession or as supervised doses. The pharmacy also provides medicine stock to the healthcare units in the wings. The pharmacy team supports the administration of medicines to people on the wings.

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 suitably identifies and manages the risks associated with its services. The pharmacy protects people's private information. And it keeps the records it needs to by law. The pharmacy has up-to-date written procedures for the team to follow to help ensure the pharmacy's services are provided safely. The pharmacy team members respond appropriately when dispensing mistakes happen. They identify what caused the mistake and they take action to prevent a recurrence. The team members have a clear understanding of safeguarding and how to raise a concern.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The team members demonstrated a clear understanding of their roles and they worked within the scope of their role. The pharmacy had a procedure for managing dispensing mistakes which were identified during the final check. The pharmacy kept records of these mistakes which were known as near misses. The team members recorded the cause of the near miss, their learning from the mistake and the actions they had taken to prevent the mistake happening again. The team had separated products that looked alike or had similar names to reduce the risk of selecting them in error. Dispensing mistakes that had reached the person were recorded and shared with the pharmacy team and the wider healthcare teams. And these were discussed as part of the medicines management meetings. There were regular team meetings to discuss changes to be made to reduce near misses and errors. Recently it was discussed that the noise when the technicians came back from the wings was a contributory factor. And steps had been taken to reduce this.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacy displayed a legally compliant RP notice. The team had completed training about the General Data Protection Regulation (GDPR). The team separated confidential waste for removal by a licensed contractor. All the prescriptions were printed out and kept on the wings, so that in the event of a power cut people would still be able to get their medicines. Usually the prescription on SystmOne was used, unless the prescription was for a controlled drug.

The pharmacy had safeguarding procedures and guidance for the team to follow. The pharmacists had completed the necessary up-to-date safeguarding training and all team members completed annual internal training. The pharmacy technicians administering medicines on the wings reported any concerns about people to the pharmacists and nursing team to review. Staff were rotated around the prison, every 12 weeks, to reduce the risk of grooming.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with a range of experience and skills to support its services. Team members work well together and are good at supporting each other in their day-to-day work. The pharmacy provides its team members with ongoing training, and they receive feedback on their performance. So, they can develop their skills and knowledge. There is good regional support.

Inspector's evidence

A full-time pharmacist covered the pharmacy opening hours with support from a part-time pharmacist. Another pharmacist was the pharmacy manager and was an independent pharmacist prescriber. A full-time pharmacy technician was the dispensary manager and was supported by pharmacy technicians, trainee technicians and a qualified dispenser. Some of the pharmacy technicians split their time between administration of medicines on the wings and supporting the team in the pharmacy. The pharmacists had some contact with people and were planning to increase the pharmacist-led services. The trainees were supported by experienced colleagues and had protected time to complete their training.

The support provided by the experienced team members included how to safeguard and protect themselves when moving around the prison, especially if the trainees had not worked in a prison before. The pharmacy provided online training to the team members who had some protected time to complete the training. The training included mandatory topics such as data protection and safeguarding. The pharmacy provided performance reviews for the team. This gave team members a chance to receive individual feedback and discuss their development needs. The pharmacists and senior technicians attended meetings held for all the healthcare teams. In one of these meetings, it was suggested that the time technicians were required to be back in the pharmacy was too tight and that an extra 30 minutes would benefit them. This was tried and found to be beneficial. Also, each technician was allocated one day to stay on the wing, for general housekeeping and other tasks. The pharmacy provided the team with access to data gathered for all healthcare and pharmacy teams within the company to identify trends.

There was a regional pharmacist who visited on a regular basis and shared good practise within the London prisons.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriate for the services the pharmacy provides. And the pharmacy is suitably clean, hygienic, and secure.

Inspector's evidence

The pharmacy was in the healthcare block. It was a good size with plenty of space for the team to work and store medicines. It was kept tidy. There were separate benches used for dispensing and checking. The team kept floor spaces clear to reduce the risk of trip hazards. The team kept the pharmacy clean and tidy and secure against unauthorised access. The pharmacy had separate sinks for preparing medicines and hand washing.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and it stores them properly. The team generally carries out appropriate checks to make sure medicines are in good condition and safe to supply.

Inspector's evidence

People did not directly access the pharmacy. The pharmacy technicians supported the administration of medicines in the healthcare units on the wings. The technicians helped people with their medicine queries or passed them on to the pharmacist to respond. 60% of people ordered their own repeat medicines and the technicians reviewed all the others, either selecting them for review to go on repeat, such as a sertraline prescription, or for discontinuation, as appropriate. There were plans for people to speak to a pharmacist through a clinic held by the pharmacists. This was going to start with a new medicines service, where people would be given additional advice when starting certain new medicines. The pharmacist and pharmacy technician had access to the prescribing system where prescriptions were generated. So, they could check people's medical conditions and risk assessments completed for people who received their medication in-possession. And the pharmacists routinely checked the test results for people prescribed high-risk medicines. The pharmacy technicians referred to the notes recorded on the system when people queried their medication. For example, if a person's dose had changed, they could advise the person why it had changed and who had authorised it. The pharmacy technicians recorded information onto the prescribing system such as when people refused their medication or didn't attend to receive their medication. This meant all teams involved with the person's healthcare were aware.

The nursing team advised the pharmacy team of people who were due in court so suitable preparations could be made for the person to have their medication. The pharmacy technicians provided people medication such as paracetamol under an agreed minor ailments policy. The pharmacy had 'checked by' and 'dispensed by' boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample seen showed that the team completed the boxes. The pharmacy team provided stock for the out-of-hours cupboard on one of the wings and audited the use of the stock.

The pharmacist had introduced sleep clinics which had resulted in a reduction by 60% of the number of sleeping medicines prescribed. They were planning to share their learning from this with other prisons in the group and also use the same process for reducing the prescribing of other medicines which were liable to be abused. Spot checks were made in prisoners' cells to ensure compliance on a regular basis.

The pharmacy obtained medication from several reputable sources. The pharmacy team checked the expiry dates on stock and usually kept a record of this. The team regularly checked and recorded fridge temperatures. A sample of these records showed that the temperatures were kept within the correct range. The pharmacy had medicinal waste bins to dispose of out-of-date stock. And it stored out-of-date controlled drugs (CDs) separate from in-date stock in a CD cabinet. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the

alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. The team keeps the equipment clean and uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided including a range of CE marked equipment to accurately measure liquid medication. The pharmacy had two large pharmacy fridges. The pharmacy computers were password protected and each team member had their own authorised login. 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.