

Registered pharmacy inspection report

Pharmacy Name: HMP Brixton, Jebb Avenue, Brixton, LONDON, SW2
5XF

Pharmacy reference: 1123347

Type of pharmacy: Prison / IRC

Date of inspection: 19/06/2024

Pharmacy context

The pharmacy is located within HMP Brixton and provides dispensed medicines to people in the prison. It dispenses medicines on a named patient basis, and it supplies these to the wings as either in-possession or not in-possession. Some medicines are supplied as stock to the wings using the pharmacy's wholesale distribution authorisation. And the pharmacy also holds a Home Office licence to supply controlled drugs.

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	1.1	Good practice	The pharmacy actively identifies risks associated with its services and makes improvements to help minimise them.
2. Staff	Good practice	2.3	Good practice	The pharmacy ensures that team members complete a comprehensive induction programme and they receive regular clinical supervision.
		2.4	Good practice	The pharmacy has a good culture of learning. It promotes learning, continuous improvement and the personal development of its team members.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy manages its services well with a clear focus on patient safety.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy identifies and manages the risks associated with its services well to help provide them safely. And it ensures that vulnerable people are protected. The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce risks. The pharmacy protects people's personal information well. And people can provide feedback about the pharmacy's services. The pharmacy keeps its records up to date and accurate.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). And team members had signed to show that they had read, understood, and agreed to follow them. The responsible pharmacist (RP) explained that the pharmacy would remain closed if the pharmacist had not turned up in the morning. And the head of healthcare would be informed. There were contingency arrangements for pharmacist cover if needed. Team members knew which tasks should only be undertaken when there was an RP signed in. And team members' roles and responsibilities were specified in the SOPs. Team members wore smart uniforms with name badges displaying their role so that they were easily identifiable throughout the prison.

Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and reviewed monthly for any patterns. One of the pharmacy technicians was responsible for reviewing the record. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And the outcomes from the reviews were discussed openly during the regular team meetings. There were separated working stations which meant that there were fewer distractions. The RP said that this had helped minimise the number of mistakes. Dispensing errors, where a dispensing mistake had reached a person, were recorded electronically and a root cause analysis was undertaken. The RP said that there had not been any recent dispensing errors in the pharmacy.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. Prescriptions were screened, clinically checked, and printed by a pharmacist in the pharmacy's office. The accuracy checking technicians (ACTs) knew which dispensed prescriptions they could check and which ones they shouldn't check.

The pharmacy had current professional indemnity insurance. The right RP notice was clearly displayed, and the RP record was completed correctly. Controlled drug (CD) registers examined were filled in correctly, and CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The RP said that all CDs were physically checked by two people at the time of supply and receipt and the balance in the register was also checked at that time.

Confidential waste was removed by a specialist waste contractor, and computers were password protected. Only authorised personnel had access to the pharmacy. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Team members had completed training about protecting people's personal information.

The complaints procedure was available for team members to follow if needed. The RP said that there had not been any recent complaints. If the pharmacy received a complaint, the head of healthcare would be informed, and it would be recorded electronically. The RP said that she had recently received positive feedback from a person she had helped with an issue.

The head of healthcare was the safeguarding lead for the site. Some team members had completed the Practice Plus Group safeguarding level three face-to-face training and others were waiting to attend the course. Team members knew potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The RP said that there had not been any recent safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✓ Good practice

Summary findings

The pharmacy has enough team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions to help improve the systems in the pharmacy. And they have regular team meetings. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There were two pharmacists and four pharmacy technicians working during the inspection. The RP explained that the team members had to apply for leave well in advance and holidays were staggered to ensure that there were enough staff to provide cover. The pharmacy was up to date with its dispensing and team members communicated effectively during the inspection to ensure that tasks were prioritised.

Team members had access to online training modules via the learning management system (LMS). Training was monitored by the business manager for the site. Team members had monthly clinical supervision to ensure that they were working safely and following the SOPs. The RP said that team members had one hour of protected training time each week which meant they could complete training at work. The RP said that team members could access the training online at home if they preferred. Each team member had a comprehensive induction plan with a competency sign off and agreement. They also had an individual development plan and training record folder. Team members had recently undertaken some face-to-face basic life support training and enhanced conflict resolution training. There were fortnightly team training sessions which were led by the RP. A recent session was about the Inclisiran treatment. Some team members had to research information about the treatment and deliver a presentation to the rest of the team. All training sessions were uploaded into a shared folder, so were accessible to team members who were not available for the training. Team members were aware of the continuing professional development requirement for professional revalidation.

The pharmacy had fortnightly meetings to discuss any issues, what was and wasn't going well, things to know and achievements to recognise. The minutes of the meeting were recorded, and attendees had to sign to show that they had read them. Representatives of the pharmacy team attended weekly 'safer prescribing' meetings and multi-professional complex case clinic meetings, and monthly medicines management meetings. And the second pharmacist said that team members were openly praised when they had performed well.

Team members felt able to make professional decisions and were encouraged to speak up when things were not going well. They had one-to-one performance reviews with their line manager every six months. And they felt comfortable about discussing any issues with the pharmacist or making any suggestions. There were some targets but team members said that these would not affect their professional judgement.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access, and it was bright, clean, and tidy throughout. Air conditioning was available, and the room temperatures were suitable for storing medicines and these were recorded daily. There was ample workspace, and it was free from clutter. The sink areas were clean and there was hot and cold running water.

The RP said that team members could use one of the healthcare rooms to speak in private with people if needed. And conversations at a normal level of volume in the rooms could not be overheard.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy manages its services well with a clear focus on patient safety. It tailors its services to meet the needs of its patients. This means that people with a range of needs can receive care. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

An interpreter service was available if needed with the telephone and access number available on the wings. Pharmacy technicians worked in the prison during the administration times. The pharmacist said that people could ask for a medication review. The need for these reviews was sometimes identified when the prescriptions were screened by the pharmacist. The second pharmacist said that the pharmacy would arrange a review for the person. The pharmacists ran daily minor ailment clinics which allowed people the opportunity to speak with a pharmacist. Team members were easily identifiable when walking to the wings and people could speak with them at that point if needed.

People were encouraged to re-order prescriptions for their medicines before they ran out. And the pharmacy ensured that these were processed promptly. The pharmacists also regularly checked which people had not requested their medicines and prompted them to put a request in. People who received their medicines as weekly in-possession (IP) had to request their next prescription when they collected their medicines. Team members sent electronic messages to the doctors and mental health team if there were any issues regarding a person's prescription.

The pharmacy used SystmOne to record interventions and any communication with prescribers. Tasks were sent to the prescriber if a person did not have up to date blood test results. This was to ensure that the pharmacists could undertake a clinical check on the prescription before it was dispensed. Team members recorded when a medicine from the general sales list had been supplied to a person and the reason for supply was recorded. Prisoners were referred to a doctor if they had requested one of these medicines on three separate occasions. If a person had not attended for their morning medication, team members requested that an officer ask them to attend for the afternoon round. Missed doses were recorded on SystmOne. If a person missed three doses of their methadone, the substance misuse nurse would be informed on the day, and they would contact the person.

The RP explained that the pharmacy issued a new blood glucose monitor to people with diabetes. They were also given test strips and a small sharps bin. The test strips were put on a repeat prescription so that the person did not need to see a doctor each time they needed further supplies. The RP said that there were currently no people taking warfarin or methotrexate. He said that he would check monitoring record books if a person was taking a higher-risk medicine. And the pharmacy had access to the patient's medication record to check that the person was having the relevant tests done at appropriate intervals. The RP said that the pharmacy supplied valproate medicines to a few people. People were routinely informed about the potential risks when taking these medicines and this was recorded on SystmOne. The pharmacy dispensed valproate medicines in original packs and all relevant information was routinely provided.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the MHRA. The RP explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. And this was shared monthly with the wider healthcare team in the medicines management meeting. Stock was stored in an organised manner in the dispensary. Expiry dates were checked monthly, and this activity was recorded. Items with a short shelf-life were clearly marked. Short date stock lists were kept, and items were removed from dispensing stock and disposed of appropriately. CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that had been returned to the pharmacy and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided to people who had their medicines IP when their prescription could not be dispensed in full. The prescriptions were clearly marked that there was an 'owing' and the bag that the medicines were in was also clearly marked. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and supplied.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Triangle tablet counters and capsule counters were available and clean. A separate counter was marked for cytotoxic use only which helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. The electronic methadone dispenser was calibrated daily and cleaned weekly, and this activity was recorded. Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed. There were several computers available which helped team members manage the workload effectively.

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.