General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP Leeds, 2 Gloucester Terrace, Stanningley Road, Leeds, West Yorkshire, LS12 2TJ

Pharmacy reference: 9010352

Type of pharmacy: Prison / IRC

Date of inspection: 22/06/2022

Pharmacy context

The pharmacy is inside HMP Leeds a 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 and people have some access to the pharmacist for advice on their medication.

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

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 errors happen. They identify what caused the error and they act to prevent future mistakes. 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 had read and signed the SOPs to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions. For example, when the pharmacist spotted an error during their check of the dispensed prescription. The pharmacy kept records of these errors known as near misses. The team members sometimes recorded the cause of the near miss error, their learning from the error and the actions they had taken to prevent the error happening again. Some entries had the same reason for the actions taken rather than capturing the individual reflection by the team member involved. For example, the description 'changed' was often written. One of the pharmacy technicians undertook a regular review of the near miss reports as part of the patient safety review process. And discussed the outcome with the team to identify opportunities to prevent the same errors from happening again. For example, the team had separated products that looked alike and sound alike to reduce the risk of selecting them in error. The team had also been reminded to reduce distractions when dispensing such as not talking to each other. Errors that reached the person were recorded and shared with the pharmacy team and the wider healthcare teams. And were discussed as part of the medicines management meetings. The pharmacist and senior pharmacy technician attended patient safety meetings involving all healthcare professionals were such incidents where discussed.

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 Regulations (GDPR). The pharmacy technicians on the wings ensured there was sufficient space for each person to receive their medication without being overheard by other people. The team separated confidential waste for shredding onsite.

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.

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 team members discuss ideas to enhance the delivery of the pharmacy's services to ensure people receive safe and effective care. The pharmacy provides team members with ongoing training and they receive some level of feedback on their performance. So, they can develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist covered the pharmacy opening hours with support from a part-time pharmacist and a company employed pharmacist who worked across several prison pharmacies. The part-time pharmacist was an independent pharmacist prescriber. A full-time pharmacy technician was the pharmacy manager and was supported by pharmacy technicians, one who helped manage the team, trainee technicians and qualified dispensers. 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 the 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 team held regular meetings and team members could suggest changes to processes or new ideas of working. The pharmacists and senior technicians attended meetings held for all the healthcare teams. The pharmacy manager had suggested changing the policy of all medicines for people in the segregation unit being not-in-possession to in-possession following a risk assessment. The pharmacy manager had identified that some people had been assessed to safely have their medication in their possession but when they transferred to the segregation unit this was taken away. This change was agreed with the senior healthcare team and had been implemented. The pharmacy provided the team with access to data gathered for all healthcare and pharmacies teams within the company to identify trends. The pharmacy team had access to a well-being cupboard that contained items such as sanitary towels and instant food snacks.

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. 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 the preparation of 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 supports the team to introduce changes to the way medicines are supplied to people to ensure they have effective care. The pharmacy gets its medicines from reputable sources and it stores them properly. The team generally carries out checks to make sure medicines are in good condition and appropriate 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 three times a day with some evening support. The technicians helped people with their medicine queries or passed them on to the pharmacist to respond. The pharmacist recorded on the prescription any advice to be given to the person by the pharmacy technicians when handing over the person's medication. There were some opportunities for people to speak to a pharmacist through a monthly clinic held by the pharmacists. This mostly provided a review of the person's medication to see if the person had any concerns about their medication and that it remained suitable for them. The pharmacists were planning to expand the range of services they could provide.

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. However, the pharmacists did not routinely check 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 such as the dose they were due to have. So, they could advise the person why the dose had changed and who had authorised it. The pharmacy technicians recorded information onto the prescribing system such as people who refused their medication or didn't attend to receive their medication. This meant all teams involved with the person's healthcare were aware. The pharmacy technicians joined the daily healthcare briefing and reported such concerns.

The pharmacy manager had recently worked with the healthcare team to change the policy of people in the segregation unit being given the medication rather than having it in possession. This meant people who were taking medication such as antibiotics four times a day who had them in their possession before transferring to the unit could continue to do so. An appropriate risk assessment was completed at the time the person transferred to the unit and when they returned to the wing. 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 pharmacist prescriber supported the issuing of prescriptions for people to take out (TTO) when released. The pharmacy technicians provided people medication such as paracetamol under an agreed minor ailments policy.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. 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 found the team completed the boxes. The pharmacy team provided people with the medication they took themselves

in single dose compliance packs or appropriately labelled white boxes. The pharmacy team provided stock for the out-of-hours cupboard on one of the wings but it didn't audit the use of the stock to ensure it was being appropriately supplied.

The pharmacy obtained medication from several reputable sources. The pharmacy team checked the expiry dates on stock and usually kept a record of this. However, sections such as the date check of liquid medications had not been completed for several months. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. And they kept a list of medicines due to expire each month so they could check if the item was still in stock and remove it. No out-of-date stock was found. The team regularly checked and recorded fridge temperatures. A sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock. And it stored out-of-date controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. 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 usually 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 the 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 equipment to accurately measure liquid medication. The pharmacy had two large pharmacy fridges. Both had glass doors which enabled the team to check the stock inside without prolong opening of the door. The team regularly cleaned and calibrated the electronic pump used to measure CD liquid medication. This helped to ensure the doses measured were accurate. The pharmacy computers were password protected and each team member had their own authorised log-in.

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.