General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP Wormwood Scrubs, Du Cane Road, London, W12 0AE

Pharmacy reference: 9010353

Type of pharmacy: Prison / IRC

Date of inspection: 15/06/2021

Pharmacy context

The pharmacy is inside HMP Wormwood Scrubs and provides services to the prison. This includes the dispensing of medicines and administering of medicines on the wings. The pharmacist provides some additional services such as medicine reviews. The pharmacy also has appropriate authority to supply medicines including controlled drugs as stock to the healthcare services within the prison. The inspection took place 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	1.8	Good practice	The pharmacy team have a good understanding of safeguarding. They explained how they went and spoke to vulnerable people who weren't coming to the treatment room on the wing to take their medicine and the action they took to support them.
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	4.2	Good practice	The pharmacy team focuses on ensuring people have safe and effective care. For example, a pharmacist reviews people's medicines in reception to highlight complex cases and ensure there is early intervention.
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 well. The pharmacy maintains the records it should. Its team members have identified roles and accountabilities. They support and assist vulnerable people well. The pharmacy deals with its mistakes responsibly. But because it does not record all its mistakes or regularly review them, team members may be missing some learning opportunities to make things safer.

Inspector's evidence

The pharmacy had processes in place to identify and manage the risks associated with its services. This included for COVID-19. The pharmacy had a set of standard operating procedures (SOPs), local operating procedures (LOPs) and a pharmacist's guide to dispensing services at the prison. They provided guidance for the pharmacy team about how to carry out their tasks correctly. The staff had signed them, and they understood their roles and responsibilities. Some of the procedures had required a review in February 2021. The pharmacist had updated the procedures, but they had not yet been implemented because they were going through a review process.

The pharmacy had a process for recording dispensing mistakes that were identified before reaching a person (near misses). Staff described how they discussed any near misses with the accuracy checker when they were highlighted to them. They said the details were recorded and reviewed every month. If they regularly made mistakes, they had to record and log the items they dispensed. Medicines that were similar in packaging had been separated and a notice board in the dispensary highlighted common errors. However, when recent near miss records were checked very few mistakes had been recorded. The pharmacist explained that they had not been recorded regularly due to a lack of staff. She said that she highlighted common and frequently noticed mistakes to the team and that near misses were also discussed at their team meetings, but that regular monthly reviews had not been taking place.

Incidents were brought to the attention of the principal pharmacist and recorded on Datix. The pharmacist reviewed each one, the details were collated, fed back to the team, and raised at the medicine's management meeting every month. People could make a written complaint about the pharmacy service through boxes placed on the wings. They were passed to the principal pharmacist to investigate. She spoke to the team and the person who raised the complaint to resolve the issue or would call them in for a medication review.

The pharmacy had audit trails to support the safe delivery of its dispensing services. The clinical check was also recorded on the patient's electronic record (SystmOne). The final check for accuracy was by the responsible pharmacist (RP) or the accuracy checking technician (ACT). Prescriptions printed off from SystmOne did not have an electronic signature. The pharmacy team asked prescribers to sign prescriptions for controlled drugs (CDs), but other prescriptions were not always signed. The pharmacist said that prescribers had to log onto SystmOne with their own password to generate a prescription and they did not always have time to sign prescriptions. Signing a prescription is a legal requirement and ensuring this was continually met was stressed at the time.

The pharmacy maintained appropriate records to support the safe delivery of pharmacy services. These included the RP record, CD registers, and fridge temperature records. Balances for CDs were

checked regularly. 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 placed into a separate bin before being appropriately disposed of by the prison. 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.

Pharmacists were trained to level 3 to safeguard vulnerable people and other staff had mandatory training to complete about this on the e-learning platform. The pharmacy technicians explained that if vulnerable people on the wing did not come to the treatment room for their medicine, they went to their cell to find out why they hadn't attended. If they refused or after the second day of not attending, they referred them to the nurse for review.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has adequate numbers of staff to manage its workload. Its team members are given opportunities for self-development. And they have access to ongoing training modules. This helps keep their knowledge and skills up to date. Staff can raise concerns if necessary.

Inspector's evidence

At the time of the inspection, there were two pharmacists and two pharmacy assistants in the dispensary. In addition, pharmacy technicians were mainly based in the treatment rooms on the wings. The pharmacy also had two accuracy checking technicians (ACTs) who were not present during the inspection.

However, the pharmacy had experienced staff shortages and some staff turnover. Other than the principal pharmacist and a recent addition of an 'early days' pharmacist (see Principle 4), locum pharmacists and ACTs were being used. Some staff had been shielding due to pregnancy, others had to isolate because of testing positive for COVID-19, and this had left the team short. On occasion, the principal pharmacist described having to administer medicines on the wings. And some routine tasks had not been routinely completed (such as the recording and reviewing of near miss mistakes). But, new members of staff felt supported and team members in training were given time to complete their course at work.

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. The principal pharmacist also provided regular training to the team on various topics. Team meetings were usually held every month, but this had not been happening recently due to the staff shortages.

Staff described having regular one to one performance reviews where they were asked about personal targets and objectives. One member of staff described asking to become a technician and was subsequently enrolled onto the appropriate course. She had also been asked about how the pharmacy's internal processes could improve and had given suggestions. These had been implemented and involved creating additional audit trails to monitor the wholesale of medicines to the wings. The pharmacist could also raise concerns at the local delivery board (LDB), these were meetings run by the prison.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure and appropriately maintained. The premises have enough space to deliver the services it provides. Its team members keep the premises clean. And it has measures in place to help stop the spread of Covid-19.

Inspector's evidence

The pharmacy was in the healthcare block of the prison. It was of a reasonable size with enough space for its workload. The dispensary had areas clearly marked for the various processes and clear workflows in place. The temperature in the pharmacy was suitable to store medicines. The premises were clean and lit appropriately. Staff cleaned the pharmacy regularly. The premises were secure against unauthorised access.

Due to COVID-19, a notice on the door highlighted that only three people at a time could be present in the pharmacy. The pharmacy also had notices to ensure staff washed their hands frequently; hand sanitisers were present for the team. Staff worked in different areas of the dispensary and markers had been placed on the floor to help with social distancing. Staff were wearing surgical face masks. Risk assessments for COVID-19, including occupational ones for the team had been completed. Team members had been vaccinated against COVID-19 and twice-weekly testing with lateral flow tests were taking place.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely. The pharmacy team focuses on the people receiving services to make sure they have effective care. The pharmacy gets its medicines and medical devices from reputable sources and stores them safely. It takes the right actions if any medicines or devices are not safe to use to protect people's health and wellbeing. And the pharmacists have made suitable interventions to protect people's health and wellbeing.

Inspector's evidence

There was no patient access to the pharmacy. The prison had a low proportion of elderly people. One person received their medicines in a multi-compartment compliance pack. The pharmacist explained that this was a local prison, linked to the courts so people often did not stay long and might be new to the prison environment. To help people using the healthcare service the pharmacist had written a comprehensive booklet which explained to people how medicines were managed in prison. The pharmacy also had introduced a process for people to order their own in-possession medicines (in-possession medicines are medicines that the prison has decided are safe for some prisoners to hold and take themselves) to encourage and support them in managing their own healthcare.

The team used baskets to hold prescriptions and medicines during the dispensing process. This helped keep them separate. Staff did not record their details on the dispensing label. Instead details were marked on the prescription to identify the clinical check, the dispenser and accuracy checker along with a separate sheet with information about who had taken the medicines to the wings. The pharmacist said these records allowed her to quickly find out who had been involved in any mistake. The pharmacy mostly supplied medicines in original packs, But medicines supplied for seven days in-possession were kept in the original blister but placed inside a clear bag instead of a carton. This was labelled with the relevant details including the batch number and expiry date. However, clear bags are not suitable containers for medicines. The pharmacist said that she would review this process.

The pharmacy's stock was stored appropriately in the dispensary, and medicines being wholesaled for use on the prison wings were kept separately. The pharmacy used licensed wholesalers to obtain medicines and medical devices. The team date-checked medicines for expiry regularly and kept records of when this had happened. Short-dated medicines were identified. Medicines removed from people when they arrived at the prison were stored within designated containers before being collected and destroyed. The pharmacy received drug alerts by email and took appropriate action to keep people safe. The pharmacy kept suitable records to show this.

The pharmacy technicians were responsible for the management of medicines, administration, and supply of minor ailments on the wings. The technicians were rotated every three months on each wing. This gave them time to understand people's needs and to provide continuity of care. It also allowed technicians to complete quarterly clinical governance audits to check compliance at the end of the period. The technicians also gave advice and checked on vulnerable people who did not attend to receive their medicine.

During COVID-19, medicine reviews had been stopped but after the pharmacist raised her concerns they had been reinstated. After identifying an issue linked to a person's initial assessment and in

response to the time it took to resolve this, the pharmacist identified that an additional pharmacist (known as the 'early days' pharmacist) was required at the initial assessment stage in reception to review people's medicines. Since their employment in May 2021, nine interventions had been identified which had led to better care for people with complex needs.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has an appropriate range of equipment and facilities for the services it provides. Its team members keep them clean.

Inspector's evidence

The pharmacy had a range of equipment. This included clean counting trays, legally compliant CD cabinets and an appropriately operating pharmacy fridge. Records showed that the fridge stored medicines correctly between 2 and 8 degrees Celsius. COVID-19 vaccinations had been stored in a fridge whose temperature was monitored over 24 hours using a data logger. The dispensary sink was clean. The pharmacy had hot and cold running water available. Staff also had access to the internet.

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.