General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** HMP Wakefield, 5 Love Lane, Wakefield, West Yorkshire, WF2 9AG

**Pharmacy reference:** 9010354

**Type of pharmacy:** Prison / IRC

**Date of inspection:** 09/11/2022

## Pharmacy context

This pharmacy is located in HMP Wakefield, a category A men's prison. The pharmacy's main activity is dispensing medicines to people within the prison. And supplying some medicines in multi-compartment compliance packs to help people take their medication. The pharmacy team supports the administration of medicines on the wings and provides people with advice about their medication.

## 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 generally identifies and manages the risks associated with its services. It has written procedures for the team to follow to help ensure the pharmacy's services are provided safely. The pharmacy protects people's private information and it keeps the records it needs to by law. The pharmacy team members respond appropriately when errors happen. They identify the cause and they act to prevent future similar errors. The team provides people with the opportunity to raise concerns about the pharmacy's services. And it acts adequately in response to the concerns raised. However, it doesn't review the concerns raised to identify opportunities to enhance the safe and effective delivery of the pharmacy's services.

### 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. All team members had read the SOPs and most had signed the SOPs signature sheets 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 known as near misses. The team member was usually told of their error rather than identifying it themselves so they could reflect on why it happened. The pharmacist recorded each error instead of the team member involved so they didn't have the opportunity to fully learn from their error. The pharmacist identified common errors involved the dispensing of incorrect quantities and reminded the team members to double check the quantities they dispensed. The pharmacy used a digital platform to record errors that were made after the person had received their medicine, known as dispensing incidents. All the team members discussed the dispensing incidents and the actions taken to prevent a similar error from happening again. The team was reminded to follow procedures with the dispensing of prescriptions following an incident when a prescription was released from the pharmacy that wasn't checked by the pharmacist. The dispensed medicine was correct but the team was reminded to not bag the prescription if there was no evidence the pharmacist had undertook their check.

The pharmacy had a procedure for handling complaints and feedback. People were invited to complete a form to raise concerns with the pharmacy team which were usually managed by the senior pharmacy technician. Most complaints were about delays to the receipt of people's in-possession medication. The team was aware of these concerns and had taken some action to address them. However, the pharmacy didn't monitor these concerns to identify patterns that could help the team take appropriate action to ensure people received their medication on time.

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 completed regular balance checks of most of the CD registers to help identify errors such as missed entries. The team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding offsite. The pharmacy had safeguarding procedures for the team to follow and team members had completed appropriate training. This included the pharmacist who had completed level 2 training from the Centre for Pharmacy

Postgraduate Education (CPPE). The team liaised with the safeguarding lead in the prison when safeguarding concerns arose.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has a team with the appropriate range of experience and skills to safely provide its services. Team members work well together, even under the pressure they sometimes feel. They suitably support each other in their day-to-day work and they discuss ideas to support the delivery of the pharmacy's services. The team members have opportunities to complete training to develop their knowledge and skills. They benefit from identifying areas of their own practice they wish to develop, and the pharmacy helps them to achieve this.

### Inspector's evidence

One full-time pharmacist with extra pharmacist support covered the pharmacy opening hours. The pharmacy team consisted of a full-time accuracy checking technician (ACT), a full-time technician, a part-time locum pharmacy technician and a full-time dispenser. The pharmacy technician had been in post a few weeks. In addition to supporting the pharmacy services the pharmacy technicians led the administration of medicines on the wings alongside the team of nurses. The pharmacy technicians and nurse colleagues worked well together when administering people's medicines and dealing with people's queries.

The pharmacy had faced some staffing challenges in recent months when experienced team members left and the pharmacy manager was on a planned absence. This had impacted on the efficient delivery of pharmacy services particularly the timely supply of some people's medication. The ACT had been supported by nurse colleagues when administering medicines on the wings. But the team members struggled to manage the workload and were several days behind with the processing of prescriptions. The pharmacy had recruited more team members who were due to start in post in a few weeks and the pharmacy manager was returning from their planned absence.

The team members accessed e-learning modules to keep their knowledge was up to date. And since team numbers had recently increased they were given some protected time at work to complete the training. The pharmacy technician had experience with the prescribing platform used by the prison. And was training the team members on the variety of tools the system could support them with. The pharmacy provided team members with an opportunity to review their personal development and to update their skills. They were given time before the review meeting to reflect on their achievements and ambitions. The pharmacy technician had expressed interested in undertaking ACT training which the pharmacy was supporting.

Team members worked well together and supported each other. The ACT shared key points from the healthcare team meetings with team members. And they discussed information provided by the head office team. The pharmacy used a communication book to capture important information for all team members to be aware of.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises are clean, secure and suitable for the services provided.

### Inspector's evidence

The pharmacy was in the healthcare block and was an adequate size for the volume of work the team undertook. Its size generally enabled the team members to separate the dispensing and checking of prescriptions and to keep floor spaces clear from the risk of trip hazards. But occasionally the limited space resulted in the team storing baskets holding prescriptions and dispensed items on top of each other, creating an increased risk of errors. The pharmacy had a separate sink for the preparation of medicines. A nearby toilet provided hot and cold running water.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides a limited range of services to support people's health needs. It generally manages its services well to help people receive appropriate care and it suitably responds to delays with the supply of some people's medication. The pharmacy gets its medicines from reputable sources and it stores them properly. The pharmacy team generally carries out checks to make sure medicines are in good condition and appropriate to supply.

### Inspector's evidence

People had no direct access to the pharmacy and they could only speak to a team member when they were in the healthcare units on the wings. The pharmacy technicians led the administration of medicines in the treatment centre linked to all four wings. The administration of medicines mostly took place at 8am and 5pm but the team arranged for people who had medicine doses outside of these times to receive their medication. Several people had complex long-term healthcare needs and the technicians generally helped with any queries people had about their medication. Or they made a record of the question to ask the pharmacist about before replying to the person. The pharmacist was mostly based in the dispensary so people had limited access to them for support with their healthcare needs. The senior pharmacy technician attended the daily handover meetings with the healthcare team. And the pharmacist was sometimes asked to contribute to the monitoring of medicines such as those liable to misuse. The pharmacy technicians worked with healthcare colleagues to synchronise people's medicines so they could receive all their medication at the same time.

The pharmacist and pharmacy technicians had access to the prescribing system that generated prescriptions. So, they could check people's medical conditions and the risk assessments completed for people receiving their medication in-possession (IP). Around 75% of people had all or some of their medication as in-possession and there was an up-to-date IP policy to support this. The pharmacy technicians were involved with completing the risk assessments for each person which were reviewed every 12 months or sooner if the person's circumstances changed. They also supported the healthcare teams with conducting spot checks of medicines kept in lockable storage facilities in the cells. The pharmacy technicians supplied the in-possession medicines at a specific time each day but provision was made for people who couldn't attend at the allotted time. Many people experienced delays with the receipt of their IP medication as it had not arrived from the pharmacy. At the time of the inspection several people reported delays of three days or more and a few had missed their doses. The senior technician handing out the IP medicines assured people their medication would be available later that day.

The IP risk assessment included a check on whether the person needed support with taking their medication such as receiving their medicines in multi-compartment compliance packs. The pharmacy technicians advised people on how to use the packs to ensure they took their medication correctly. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs.

The team members separated the labelling, dispensing and checking of prescriptions and they used baskets to isolate individual people's medicines to help prevent them becoming mixed up. The team used coloured baskets to differentiate between the area of the prison the prescriptions were for and

urgent ones. The pharmacy had checked by and dispensed by boxes on the dispensing labels to record who in the team had dispensed and checked the prescription. A sample of completed prescription found the team filled-in both boxes.

The pharmacy obtained its medicine stock from several reputable sources. The team members regularly checked the expiry dates on stock but didn't keep a record of this. They marked medicines with a short expiry date to prompt them to check the medicine was still in date, no out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening so the team could assess if the medicines were still safe to use. The team members checked and recorded fridge temperatures each day. A sample of these records showed a few readings were outside the correct range. But only one entry captured the actions taken which were resetting the thermometer and taking a second reading which was within the correct range. The pharmacy stored CDs in legally compliant cabinets. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. 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 pharmacy 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 and a large pharmacy fridge. This had a glass door to enable the team to check the stock inside without prolong opening of the door. The pharmacy computers were password protected and each team member had their own authorised login.

## 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. |