General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP Bullingdon, Patrick Haugh Road, Bicester, Oxfordshire, OX25 1PZ

Pharmacy reference: 9010355

Type of pharmacy: Prison / IRC

Date of inspection: 10/07/2019

Pharmacy context

The pharmacy is situated inside the prison healthcare unit. It only dispenses medicines to people in the prison. The team is an integrated part of the wider healthcare team within the prison and provides reviews for people with long-term conditions. The pharmacy is registered because it supplies medicines to a separate company within the Care UK umbrella.

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

Members of the pharmacy team identify and manage risks effectively. They are clear about their roles and responsibilities and they work to professional standards. The team members sometimes record mistakes that they correct during the dispensing process. They learn from all their mistakes to avoid problems being repeated. The pharmacy keeps its records up to date and these show that it is providing safe services. It manages and protects information well and it tells people how their private information will be used. The team members also understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had written procedures to tell the team how they should undertake the work in the pharmacy. These were on the company's computer system. The procedures were reviewed regularly and had been read by the staff. They were generally followed. There were separate procedures for the team's work outside the pharmacy, when managing medicines in the prison setting.

The written procedures said the team members should record any mistakes in the process to learn from them. They recorded some of these but discussed others as they arose. The team had regular get-togethers to discuss issues, but these were not documented. A team member described that there had been a few near misses involving different strengths of medicines, and they had separated some of the medicines to reduce selection errors.

The pharmacy conspicuously displayed the responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice.

Feedback was sought about the service from people who used the pharmacy, through questionnaires. The last responses had been very positive about the improvements in the service provision over the past year. People had reported that they were no longer having issues with not receiving medicines on time.

The pharmacy had professional services insurances in place. The pharmacy team ensured that the controlled drugs registers were up to date and legally compliant. The team did weekly checks on the recorded balance and actual stock of controlled drugs to ensure that there were no missing entries. Fridge temperatures were recorded daily and were within the recommended range for storing medicines safely.

Confidential waste was removed by a licensed waste contractor on a fortnightly basis and was stored in a dedicated bin until that time. The rest of the confidential material was kept in the pharmacy and the computers were password protected. It was observed that staff only used their own NHS Smartcards,

removing them when they stopped using the computer. There was an electronic pharmacy patient medication record system which was password protected.

All the staff had undertaken safeguarding training and had completed relevant professional training. They were all aware of the issue of grooming of staff by patients and they had had training on this matter. They said that they would always tell another member of staff about anything which made them feel uncomfortable.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe services. Its staffing rotas enable it to have good handover arrangements and effective staff communication. Training is provided by the company and staff find this useful to help keep their skills and knowledge up to date.

Inspector's evidence

The two pharmacists had sufficient overlap each day which meant that there was good communication and flexibility in the team. There were seven technicians working in the pharmacy and prison, administering medicines to people using the pharmacy's services as well as dispensing, querying prescriptions and risk assessments. Some of the technicians were accredited checking technicians. There was also a qualified dispenser.

The team worked well as an integrated part of the wider healthcare team and were involved in decisions made by the prescribers. The pharmacy manager had recently introduced a technician to work on one of the wings (the induction wing) to improve patient care by reconciling the medicines brought in by people in a more timely manner and to stop medicines disappearing between induction and the doctor seeing the patient the next morning.

The team had regular training provided, both by the prison and the care provider. This kept the staff up to date with current issues and policy. No targets were set for the staff which conflicted with their professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment from which people can receive healthcare.

Inspector's evidence

The premises were clean, tidy and bright and of a suitable size for the tasks undertaken. There was a consultation room available to see people on an individual basis. The premises were secured against unauthorised access. The premises had air-conditioning and adequate hand-washing facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective, and it gets its medicines from reputable sources. Pharmacy team members are helpful and give advice to people about where they can get other support. The team is integrated well into the healthcare service provided to people in the prison. The team monitors prescribing and makes decisions on in-possession risks to ensure that the way the medicines are supplied to people is most appropriate for them.

Inspector's evidence

The prisoners could access pharmacy advice via the technicians on the wings and by appointment with the pharmacist. The pharmacy used a dispensing audit trail to identify who had dispensed and checked each item. This included who had labelled the prescription. So, accredited checking technicians (ACTs) could safely check items they had not been involved in preparing. If an ACT produced a repeat prescription for the prescriber to sign, this was printed on pale yellow paper, again differentiating it so that it would not be checked by the accredited checking technician. The use of baskets helped to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another.

There were five people who were supplied their medicines in multi-compartment compliance aids. The records kept about these compliance trays were sufficiently clear so that any of the team could dispense them, if needed. The pharmacy thought about whether or not compliance trays were suitable for people. One person was supplied sodium valproate in a compliance aid despite the stability issues of the medicine, as this was the best option for this person. People on higher-risk medicines were monitored appropriately, with the staff checking that they had regular blood tests. This included those on ramipril and other medicines not usually checked by pharmacies, as part of the wider role in the healthcare team.

The pharmacist prescriber usually wrote prescriptions for repeat medications, meaning that GP time was saved. These prescriptions would be clinically checked by the second pharmacist so there was independent scrutiny of these. The team monitored prescribing and decisions on in-possession risks. The pharmacist would re-write prescriptions in the light of further evidence from the technicians about in-possession risk to ensure that the prisoners receiving medicines had then in the most appropriate way. The team members used SystmOne to access health records and make appointments for the prisoners when they collected their medicines which saved time.

The pharmacy got its medicines from licensed wholesalers, stored them in dispensary drawers and on shelves in a tidy way. There were 'use first' stickers on the shelves and boxes to indicate items which were short dated. Regular date checking was done. Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy. A spreadsheet was kept with all the alerts received and what actions had been taken both in the pharmacy and on the wings, if needed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for CD use, reducing the risk of cross-contamination. The pharmacy had a separate counting triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets.

The electrical equipment was in good working order and tested regularly. The pharmacy had access to current reference sources. This meant that people could receive advice based on up-to-date information.

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.