General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP Wealstun, Church Causeway, Thorp Arch, Wetherby, West Yorkshire, LS23 7AZ

Pharmacy reference: 9010356

Type of pharmacy: Prison

Date of inspection: 11/10/2022

Pharmacy context

The pharmacy is inside HMP Wealstun near Wetherby. Pharmacy team members dispense medicines to people living in the prison. They provide some of these medicines to people in multi-compartment compliance packs. And they provide advice to people about their medicines and health.

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 appropriately identifies and manages risks to its services. And it keeps the records it must by law. Pharmacy team members regularly record and discuss mistakes they make. They learn from these to reduce the risks of similar mistakes. And they generally reflect to establish whether their changes improve services and make the pharmacy safer. Team members understand their role to help protect vulnerable people. And they suitably protect people's private information.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The superintendent pharmacist's (SIs) team had reviewed the procedures between 2020 and 2022. And the procedures were reviewed every two to three years. Pharmacy team members had read the procedures since the latest reviews. And they had signed a declaration to confirm their understanding. The pharmacy manager explained that pharmacy team members would also be asked to read the procedures again if necessary after an incident in the pharmacy. Pharmacy team members' roles and responsibilities were described in each SOP. A dispenser explained their responsibilities and was clear about the tasks they could or could not complete when the responsible pharmacist (RP) was absent. Pharmacy team members wore uniforms and had badges identifying their names and roles. The pharmacist clearly displayed their responsible pharmacist notice. Pharmacy team members used various checklists to help them make sure the pharmacy complied with legal and professional requirements. Their daily checklist included tasks such as monitoring and recording the temperature in the fridge and making sure the RP records were completed. Their weekly checklist helped them to ensure tasks such as checking the expiry dates of medicines and auditing the controlled drug registers had been completed.

The pharmacist highlighted and recorded near miss errors made by pharmacy team members when dispensing. Team members discussed their mistakes with each other. This included discussion about why mistakes might have happened. And they used this information to make changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines, such as amlodipine and amitriptyline, to help prevent the wrong medicines being selected. Team members attached stickers to the shelves in front of these medicines to help draw people's attention to the risks when dispensing. The pharmacy manager analysed the data collected every month to look for patterns. And they discussed this with the team at a regular patient safety meeting. Pharmacy team members did not always capture much information about why the mistakes had been made or the changes to prevent a recurrence. And this was also the same in records of the analysis that had taken place to identify patterns. Dispensing errors, which were mistakes identified after medicines had left the pharmacy, were recorded using an electronic system. And all errors involving medicines were referred to the pharmacist to investigate. This included medicines administration errors that happened in treatments rooms on the prison wings. Records of errors were available, and they contained comprehensive information about potential causes and the actions taken to help prevent the same or similar errors happening again.

Pharmacy team members explained feedback from people was usually collected verbally. And the pharmacy manager also discussed feedback about the pharmacy and its services at regular medicines management meetings. These meetings included other people involved in managing healthcare in the prison. One recent piece of feedback had been a request for changes to medicines administration on

each wing to help prevent people who had jobs in the prison from missing their work due to delays in them receiving their medicines with everyone else. Pharmacy team members had discussed this with the prison’s management team. And now, people with jobs were prioritised to receive their medicines first each morning to help them attend work on time.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. Pharmacy team members audited the registers they used frequently against the physical stock quantity every one or two weeks. But they did not regularly audit registers for CDs they used less frequently. The pharmacy maintained a responsible pharmacist record. And this was also complete and up to date. The pharmacist clearly displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily.

Only authorised team members were able to access the pharmacy. The pharmacy had a documented procedure available to help pharmacy team members properly manage people’s confidential information. Pharmacy team members completed training about how to manage confidentiality and privacy every six months. And up-to-date records of their training was available. The pharmacy had confidential waste bags available to collect confidential waste. These bags were collected for secure destruction. Pharmacy team members gave some examples of how they would raise their concerns about vulnerable people. They explained how they would refer their concerns to the pharmacist or the person responsible for safeguarding in the prison. The pharmacy had a documented procedure explaining how team members should raise their concerns about vulnerable people. Pharmacy team members completed training via e-learning every six months.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They feel comfortable raising concerns and discussing ways to improve services. And they are confident that the pharmacy supports them and listens to their views. They complete appropriate training regularly to help keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the pharmacist manager, a trainee pharmacy technician, two dispensers and a trainee dispenser. All team members were appropriately trained or enrolled on accredited training programmes. Pharmacy team members managed the workload well during the inspection. The manager organised team members holidays to provide cover to help maintain effective delivery of the pharmacy's services. And they were able to call on pharmacy technicians and dispenser who worked elsewhere in the prison to cover unplanned absences if required.

Pharmacy team members completed regular mandatory online training modules. Recent examples included safeguarding and confidentiality. They also discussed topics with the pharmacist and each other. A dispenser explained they would raise any specific learning needs verbally with the pharmacist. And they felt they would be supported by being signposted to relevant reference sources or by discussion to help address their learning needs. Pharmacy team members explained they were usually provided with time at work to complete their training. The pharmacy had an appraisal process in place for team members. Team members had a meeting with their manager every three months to discuss their progress and any learning needs. They were invited to a meeting with other healthcare colleagues each day to discuss specific queries and concerns. Healthcare colleagues included pharmacists, nurses, doctors, dentists, and healthcare managers. And this helped different members of the wider healthcare team to take prompt actions to resolve any queries or concerns. Pharmacy team members felt comfortable raising concerns. And making suggestions to help improve the pharmacy. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and properly maintained. It provides a suitable space for the services it provides.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy’s floors and passageways were generally free from clutter and obstruction. The pharmacy kept equipment and stock on shelves and in drawers throughout the premises. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a toilet nearby, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained heat and light to acceptable levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are accessible to the people who need them. It has systems in place to help provide its services safely and effectively. And it sources its medicines appropriately. Pharmacy team members regularly provide people with appropriate information about their medicines. And team members are easily accessible to people who have questions about their health and medicines.

Inspector's evidence

The pharmacy was inside the prison, and it could not be accessed by prisoners or unauthorised staff. People were able to speak to pharmacy technicians when they received their medicines. Or book an appointment to talk to someone about their medicines or health via an electronic booking system. Their request was triaged and allocated to the most appropriate member of the healthcare team. People’s queries about medicines were referred to a pharmacist or pharmacy technician. They would book an appointment to see the person to help them resolve their query.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. The pharmacist also annotated each prescription to confirm they had completed a clinical check. Team members used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. Some people were able to manage their own medicines following a suitable risk assessment to establish whether they could safely manage their medicines “in-possession” (IP). The outcome of their IP risk assessment was documented an electronic clinical records system. And this helped pharmacy team members to establish how best to dispense their medicines. The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Pharmacy team members documented any changes to medicines provided in packs on the person’s master record sheet, which was a record of all their medicines and where they were placed in the packs. The also documented changes on their electronic clinical record. The pharmacy routinely provided other prisoners with information leaflets about their medicines each month.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines neatly on shelves and in drawers. It kept all stock in the secure pharmacy. The pharmacy had disposal facilities available for unwanted medicines, including CDs. Pharmacy team members monitored the minimum and maximum temperatures in the fridge where medicines were stored each day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members checked medicine expiry dates every five weeks. And up-to-date records were seen. Pharmacy team members highlighted and recorded any short-dated items up to six months before their expiry. And they removed expiring items during the date check before the product was due to expire. Team members also wrote the date of opening on bottles of liquids to help the team know they were fit to use.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment appropriately.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable equipment available to collect its confidential waste. It kept its computer terminals in the secure areas of the pharmacy. And these were password protected. The pharmacy’s fridge was in good working order.

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.