General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP New Hall, Dial Wood, Flockton, Wakefield, West Yorkshire, WF4 4XX

Pharmacy reference: 9010470

Type of pharmacy: Prison / IRC

Date of inspection: 23/11/2022

Pharmacy context

This pharmacy is located in HMP New Hall, a female prison and young offender institution. The pharmacy's main activity is dispensing medicines to people within the prison and to another prison. 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: Improvement Action Plan

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	2.5	Good practice	The pharmacy is good at encouraging team members to share ideas on how to improve the delivery of services. And they actively engage with other healthcare teams to implement new ways of working to support people's healthcare needs.
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 identifies and manages the risks associated with its services well. It has up-to-date written procedures that the pharmacy team follows. And it completes all the records it needs to by law. Team members suitably protect people's confidential information and they understand their role to help protect vulnerable people. The team members respond competently when errors occur, they discuss what caused the error and they act to prevent future mistakes.

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 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 involved was usually asked to identify their error so they could reflect on why it happened. However, the accuracy checking technician recorded the near miss instead of the team member involved so they didn't have chance to fully learn from their error. A sample of near miss records showed sufficient information to enable the team to identify trends and take the appropriate action to prevent future errors. 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 they'd take to prevent a similar error from happening again. The lead pharmacist used the discussions to remind the team to check there were clear dose instructions on the dispensing labels to ensure people received their medication correctly. A review of the near misses and dispensing incidents took place but the outcome was not recorded for the team to refer to. The pharmacists used the shared prescribing platform to record interventions they made with prescriptions. So, the pharmacy team and other healthcare teams were aware and to prevent similar issues from occurring again.

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 managed by the lead pharmacist or the pharmacy manager. The pharmacy sought feedback from people through annual surveys.

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 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. The team liaised with the safeguarding lead in the prison when safeguarding concerns arose. The pharmacy team worked closely with the team who managed people's healthcare needs when they first arrived at the prison especially when the person was experiencing symptoms of withdrawal. And the lead pharmacist had developed a medicines review pathway for the healthcare

team to follow when supporting people through drug and alcohol withdrawal.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an experienced team with the qualifications and skills to safely provide its services. The team members work well together and support each other and healthcare colleagues in their day-to-day work. Team members benefit from identifying areas of their own practice they wish to develop, and the pharmacy helps them to achieve this. The pharmacy supports ongoing training for team members so they can suitably develop their skills and knowledge. And they are good at sharing ideas and implementing new processes to enhance the delivery of the pharmacy's services.

Inspector's evidence

A full-time lead pharmacist who was also an independent prescriber covered the pharmacy opening hours with locum pharmacist cover when required. The pharmacy team consisted of four full-time accuracy checking technicians (ACTs) one who was the pharmacy manager, four full-time pharmacy technicians, one full-time trainee pharmacy technician and a full-time dispenser. The team worked well together and the experienced team members were given the role of mentoring new team members and trainees.

In addition to supporting the pharmacy services the pharmacy technicians led the administration of medicines on the wings alongside the teams of nurses and healthcare assistants. The pharmacy technicians and nurse colleagues worked well together when administering people's medicines and dealing with people's queries. The pharmacy technicians worked across the different wings so they could get to meet people within the prison and understand their healthcare needs. The pharmacy team regularly attended healthcare team meetings such as the medicines management group or drug strategy meetings. And key points from the meetings were shared with all the team.

The team members accessed e-learning modules to keep their knowledge up to date. And they had some protected time at work to complete the training. The pharmacy provided team members with an opportunity to review their personal development and to update their skills. Some of the pharmacy technicians had expressed an interest in the ACT training and had been enrolled on to the course. The team members were encouraged to suggest and implement new ideas of working. An ACT from one of the wings and the lead pharmacist had created an audit tool for controlled drugs (CDs). This was shared with the regional team and fed into the national CD assurance audit. One team member who supported the team responsible for checking medicines kept in people's cells had developed a template to record the outcome of the check. The completed template was captured on the person's record on the prescribing system.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and secure. The size of the premises is relatively small but adequate 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 generally manages its services well to help people receive appropriate care and to make sure they receive their medicines when they need them. It keeps records to help monitor the services it provides and to enable the team to deal with queries effectively. The pharmacy gets its medicines from reputable sources and it stores them properly. The team mostly carries out checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

People could not directly access the pharmacy but they could speak to the pharmacy technicians when they were on the wings during the administration of medicines. People had some access to the pharmacist for advice on their healthcare needs. The lead pharmacist was an independent prescriber and supported other prescribers in the healthcare team. The pharmacist worked closely with the lead GP and the two had developed a prescribing pathway for gabapentin and pregabalin for teams to refer. The pharmacy technicians started the morning medicines administration around 7am which supported people who had work commitments. However, the later administration of medicines took place around 3.45pm which was early for people prescribed evening or night-time doses.

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 as in-possession (IP). The pharmacy had an up-to-date IP policy and the technicians supported the process of completing the initial IP risk assessments and the six-month review. Most people had an up-to-date IP risk assessment but the percentage of people that had all or some of their medication as IP was low compared with other prisons. Many people had medicines prescribed as not-in-possession that were listed as low risk in the IP policy. The lead pharmacist was aware of this and was working with healthcare colleagues to improve the number of people receiving IP medicines.

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. They initialled the checked by and dispensed by boxes on the dispensing labels to record who had dispensed and checked the prescriptions. The team also marked the prescriptions to show when the pharmacist had completed a clinical check to enable the ACT to complete their checks.

The pharmacy obtained its medicine stock from several reputable sources and it had procedures in place to support the team to safely transport the medicines around the prison. The pharmacy team generally followed the pharmacy's procedures to ensure medicines were safe to supply. This included marking medicines with a short expiry date to prompt them to check the medicine was still in date. And recording the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines remained safe to use. The team checked and recorded fridge temperatures and a sample of records in the pharmacy found the readings were within the correct range. However, the fridge temperatures in the treatment rooms on the wings were not always recorded and some readings were outside the accepted range. The records didn't capture whether the teams had acted to ensure the fridges were at the correct temperature. The pharmacy stored CDs in legally compliant cabinets. And it had medicinal waste bins to store out-of-date stock. 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 its services safely. It makes sure it uses it equipment appropriately to protect people’s confidential 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. 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.