

Registered pharmacy inspection report

Pharmacy Name: HMP Wandsworth, Heathfield Road, London, SW18
3HU

Pharmacy reference: 9011226

Type of pharmacy: Prison

Date of inspection: 01/05/2024

Pharmacy context

The pharmacy is inside HMP Wandsworth. It provides services to the prison including dispensing prescriptions and administering medicines on the wings to patients. The pharmacy team provides additional services such as medicine reconciliation. The pharmacy also has appropriate authority to supply medicines including controlled drugs as stock to other healthcare services within the prison.

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

Overall, the pharmacy identifies and manages the risks associated with the provision of its services. The pharmacy maintains the records it should. Its team members have identified roles and accountabilities. They support and assist vulnerable people. The pharmacy deals with its mistakes responsibly. But because it does not record all the information it could, team members may be missing some learning opportunities to make things safer.

Inspector's evidence

The responsible pharmacist (RP) sign was correct and visible at the time of inspection. The pharmacy had up-to-date processes in place to identify and manage the risks associated with its services. The pharmacy had a set of standard operating procedures (SOPs) and local operating procedures (LOPs) which were specific to the prison. They provided guidance to the pharmacy team about how to carry out their tasks safely. The staff were able to explain their roles and responsibilities. Pharmacy technicians were able to explain what their responsibilities were both in the pharmacy and when providing services in the treatment rooms on the wings. Members of the team wore standard uniforms and had badges identifying their names and roles.

The pharmacy had processes for learning from dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes which had reached the person (errors). An accuracy checking pharmacy technician (ACT) said that he discussed any dispensing mistakes with individuals at the time a near miss was made, to raise awareness. Near misses were then recorded in the near miss log but the near miss log seen rarely recorded the possible causes of the near miss which might mean that it was harder to draw learning points from the records. The pharmacy technician reviewed the near miss log monthly and discussed the review with the pharmacist before reviewing the outcome with the team.

The pharmacy had audit trails to support the safe delivery of its dispensing services. Prescriptions were printed off from SystemOne and signed by a prescriber before they were dispensed. The clinical check by the pharmacist was recorded on the patient's electronic record (SystemOne). The final check for accuracy was by the responsible pharmacist (RP) or the ACT.

The pharmacy maintained the necessary records to support the safe delivery of pharmacy services. These included the RP record and the CD register. The entry for one item checked at random during the inspection agreed with the physical stock held. Balance checks were being completed every couple of months which was not in line with the SOP. The pharmacist said she that this had been due to staffing issues and was aiming to increase the number of balance checks being carried out.

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 disposed of appropriately. The pharmacy's dispensing system and SystemOne were password protected. The team used their own smart cards to access medication records, which could only be accessed by authorised personnel.

The pharmacy team had a good understanding of safeguarding requirements. The pharmacy

technicians had a clear understanding of what to do if vulnerable people on the wing did not attend for critical medicines. But patients were not always being released from their cells for the administration of critical medicines. The pharmacy team had identified the issue and an escalation policy introduced. The team said that there had been an improvement, but far too frequently important medicines were either delayed or omitted entirely which was a risk to patient safety.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has adequate numbers of staff to manage its workload. Staff can raise concerns if necessary. The pharmacy's 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.

Inspector's evidence

During the inspection, the pharmacy team managed the day-to-day workload of the pharmacy effectively. At the time of the inspection, there were three pharmacists. There were also twenty-one pharmacy technicians, of which seventeen were accuracy checking technicians and thirteen were medicine management technicians. In addition, there were three pharmacy assistants. The pharmacy technicians were mainly based in the treatment rooms on the wings.

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. Informal training was provided as required. Staff were supported in their development. Some of the pharmacy assistants had started the pharmacy technician course and they had protected time for training. Staff had a yearly appraisal and also had regular monthly one to one meeting with their line manager. Staff explained how they felt supported and were able to give suggestions and feedback.

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.

Inspector's evidence

The pharmacy was in the healthcare block of the prison. It was small but there was just enough space for its workload. The dispensary had areas clearly marked for the various processes and clear workflows in place. There was suitable heating and lighting, and hot and cold running water was available. Hand sanitiser was available. The premises were secure against unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its services safely. 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 pharmacy team take the right actions to support people's health and wellbeing.

Inspector's evidence

The pharmacy premises was inside the prison, and it could not be accessed by prisoners or unauthorised staff. The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by boxes' on the medicine label. In addition, the pharmacist who completed the clinical check was recorded on SystmOne. This helped identify who had completed each task. The team used trays to keep prescriptions and medicines for different people separate to reduce the risk of error. Trays were colour coded according to priority.

The pharmacist performed a clinical check of all prescribed medicines. This included checking for any high-risk medicines (such as warfarin, lithium, and methotrexate) and checking the latest blood results were appropriate. And making sure that medicines were prescribed in accordance with the prison formulary. The pharmacy had a secure process to transport medicines to the treatment rooms on the wings.

The pharmacist explained that the prison had a high number of remand prisoners which meant there was a large turnover in patients. And the number of prescriptions dispensed had increased since the previous inspection increasing pressure on the pharmacy team. Some people attended the treatment room to receive their medicines at an appropriate time. Other people were allowed to take away and keep either 7 days or 28 days of their own medicines (in-possession medicines). In-possession medicines are medicines that the prison has decided are safe for some patients to hold and take themselves. A significant number of patients had not received an in-possession risk assessment which had reduced the numbers of people receiving their medicines in-possession and further increased pressures during medicine administration. This had been due to staffing issues, but the pharmacy team were now risk assessing all patients as they came into the prison in reception and working through the back log of patients without a risk assessment.

The pharmacy technicians were responsible for most of the administration and management of medicines on the wing. They gave advice to people at the medicine's hatches. And in the contact seen they treated people professionally and with respect. They could also supply some medicines for minor ailments under a 'homely remedies' policy. The pharmacy had processes to assess and manage the medicine needs of people who had just arrived at the prison. The medicines reconciliation pharmacist screened all prescriptions for 'first night' patients and assessed the medicines they had brought in to make sure they were suitable to be used and dealt with complex cases. Medicine management technicians made sure that people were getting all their medicines by speaking to them, and where necessary checking their summary care record, phoning their surgery or pharmacy to confirm details.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacy technicians were responsible for managing medicines in the pharmacy and in the treatment rooms on

the wings. Medicines were managed appropriately. The team date-checked medicines for expiry regularly and kept records of when this had happened. Short-dated medicines were identified. The pharmacy received drug alerts by email and took appropriate action to keep people safe. The pharmacy kept suitable records to show this.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services provided. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy mainly used suitable measures for measuring liquids. There were a small number of inappropriate measures in the treatment rooms on the wings, but these were disposed of during the inspection. The pharmacy had access to up-to-date reference sources. Records showed that the fridges were in working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy's portable electronic appliances had been tested in May 2023 to make sure they were safe.

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.