General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP Manchester, 1 Southall Street, Cheetam Hill, Manchester, Greater Manchester, M60 9AH

Pharmacy reference: 9012535

Type of pharmacy: Prison / IRC

Date of inspection: 02/10/2024

Pharmacy context

The pharmacy is inside HMP Manchester. It is registered to be able to provide clozapine to people living in three other prisons nearby. The pharmacy is not open to the public. And pharmacy team members provide advice to people about their medicines and health.

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 adequately identifies and manages risks. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. The pharmacy has the written procedures it needs relevant to its services to help team members provide services safely. But many of these are out of date and may not reflect the pharmacy's current practice. Team members record their mistakes so that they can learn from them. And they make some changes to help prevent mistakes happening again.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage risks. The superintendent pharmacist (SI) was responsible for reviewing the SOPs when there was a significant change to the pharmacy's processes. And in response to a patient safety incident. But some SOPs had not been reviewed for some time, with some last reviewed in 2015. This meant they may not reflect the pharmacy's current practice. The SI explained how they had recently taken on their role as SI and were in the process of reviewing all the SOPs. And, where possible, they were aligning processes with the trusts' other prison pharmacies. Pharmacy team members had signed to confirm they had read and understood the SOPs.

Pharmacy team members highlighted and recorded errors identified before people received their medicines, known as near miss errors. And dispensing errors, which were errors identified after the person had received their medicines. There were documented procedures to help them do this effectively. They discussed their errors and why they might have happened. And they gave some examples of changes they had made to help prevent isolated near miss errors from happening again. Team members did not always record information about why the mistakes had been made or the changes they had made to prevent a recurrence to help aid future reflection and learning. Team members were unsure if anyone analysed the data collected about mistakes to identify patterns. But they gave examples of separating look-alike and sound-alike medicines to help prevent mistakes after the lead pharmacist had made them aware of patterns of mistakes with these medicines. The SI gave a clear explanation of how the pharmacy would handle and record a dispensing error. They recorded errors electronically, using a system that sent information about the error to all relevant managers. All errors were discussed and reviewed in a weekly patient safety panel. The panel consisted of the SI, the lead pharmacist, lead doctor, operations manager, and other key stakeholders. They discussed the causes of each incident, and the necessary changes to help reduce the risk of the error happening again across all teams involved.

The pharmacy had a documented procedure for handling complaints and feedback from people. Pharmacy team members explained people usually provided verbal feedback. And any complaints were referred to the pharmacists, SI or the prisons Head of Healthcare to handle. The pharmacy had current professional indemnity insurance.

The pharmacy kept accurate CD registers. It kept running balances for all registers. Pharmacy team members audited these balances each time an entry was made in the register. But this meant the registers for items not dispensed regularly were not frequently audited. Checks of the running balances against the physical stock for three products were found to be correct. The pharmacy kept a register of

CDs returned by people for destruction. And a separate register for out-of-date stock CDs that had been destroyed. It maintained a responsible pharmacist record. The record was up to date and completed accurately. The pharmacist displayed their responsible pharmacist notice.

The pharmacy kept sensitive information and materials in restricted areas. Team members collected confidential waste in dedicated bags. The bags were collected and taken for secure destruction. The pharmacy had documented procedures in place to help pharmacy team members manage sensitive information, although these had not been reviewed since 2015. Team members explained how important it was to protect people's privacy and how they would protect confidentiality. And they completed formal training on information governance and data security each year.

Pharmacy team members gave some examples of signs that would raise their concerns about vulnerable adults in the prison. And how they would discuss their concerns with the pharmacists, SI, the Head of Healthcare, and the senior prison officer for the wing where the person lived if necessary. They were also aware of how to raise concerns with the prison's appointed safeguarding lead. Team members completed formal safeguarding training every two years.

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 complete training to help keep their knowledge and skills up to date. Team members feel comfortable raising concerns and discussing ways to improve services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the SI, the responsible pharmacist (RP), three pharmacy technicians, a trainee pharmacy technician, and a qualified dispenser. Team members completed training ad hoc to keep their knowledge and skills up to date. The most recent examples of completed training included learning about vulnerable adults and people with learning disabilities. Team members also explained how they had regular discussions with the pharmacists and other colleagues. They had an appraisal with their manager every six months to discuss their progress and learning needs. And they explained how they were supported by their manager and colleagues to reach their learning goals. Some pharmacy technicians also administered medicines to people at hatches on the prison's wings. They had been properly trained to administer medicines and they refreshed their training and competence to administer every year.

Pharmacy team members explained how they would raise professional concerns with the pharmacists, SI or the prison Head of Healthcare. They felt comfortable sharing ideas to improve the pharmacy or raising a concern. And they were confident that their concerns would be considered, and changes would be made where they were needed. The pharmacy had a formal whistleblowing policy. And team members knew how to access the process, as well as reporting their concerns to the GPhC.

Team members communicated well with each other to manage their workload during the inspection. Team members felt comfortable making suggestions to improve their ways of working. They explained how they had recently changed the way they managed prescriptions where medicines were owed to people. And how they had changed the way they stored dispensed medicines in the fridge to help make prescriptions easier to find. And to help prevent errors by people selecting the wrong package. The pharmacy did not ask team members to achieve any specific performance-related targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides. The pharmacy has access to consultation rooms where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was inside the prison on the wing where other healthcare services were provided to people. It was not accessible to the public and could only be accessed by authorised team members. The pharmacy was clean, well maintained, tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. It kept equipment and stock on shelves throughout the premises. Pharmacy team members used consultation rooms elsewhere in the healthcare wing to have private conversations with people if necessary.

The pharmacy had a clean, well-maintained sink in the dispensary used for medicines preparation. It had a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained its heating and lighting to acceptable levels. Access to the pharmacy was protected by locked doors and gate, which were always kept locked.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely and effectively. The pharmacy suitably sources its medicines. It stores and manages its medicines appropriately. And it has some processes to help people understand and manage the risks of taking higher-risk medicines. But team members don't always provide people with the necessary printed information to help them manage taking their medicines properly.

Inspector's evidence

The pharmacy was not accessible to the public, or to people who lived in the prison. Medicines were provided to people from secure hatches in treatment rooms on each wing of the prison. Pharmacy team members could use the electronic patient medication record (PMR) system to produce large-print labels to help people with visual impairment take their medicines properly. And they gave examples of how they used written communication to help people with hearing impairment access their services and use their medicines safely.

Pharmacy team members were aware of the risks associated with taking sodium valproate. The prison was an exclusively male population. But team members were aware of the need to provide men with appropriate advice if they were released from prison while taking sodium valproate. And they were aware of the requirements to provide valproate to people in the manufacturer's original packaging. The pharmacy provided clozapine for people in three other local prisons. They clearly explained how they would access information about someone's latest blood test results to establish if it was safe to dispense the dose prescribed. And the action they would take if blood test information was not available. Team members had access to prescribing systems to check relevant information. And they were able to easily contact prescribers to raise queries.

The pharmacy supplied medicines to a small number of people in multi-compartment compliance packs when requested, to help people use their medicines safely. The pharmacy attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions on the backing sheets of what the medicines looked like, so they could be identified in the pack. But they did not routinely provide people with patient information leaflets about their medicines each month. Team members documented any changes to medicines provided in packs on the persons electronic patient medication record (PMR), and on the person's master record sheet which kept a record of all their medicines and where they were placed in the packs.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridges each day and recorded their findings. The temperature records were within acceptable limits. Pharmacy team members checked medicine expiry dates every three months, and they recorded their checks. They highlighted any short-dated items up to six months before their expiry. And removed these items before they were due to expire. Pharmacy team members responded to manufacturers alerts and recalls. They kept records of the recalls they had received and any action they had taken to remove affected medicines.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains its equipment properly, so it is safe to use. And pharmacy team members manage and use the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. It also had various reference resources available and use of the internet. The pharmacy had a set of clean, well-maintained measures available to help prepare liquid medicines. It had suitable equipment available to destroy its confidential waste. And it kept its password-protected computer terminals and bags of dispensed medicines waiting to be collected secure in the pharmacy.

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.