General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMP Barlinnie, Lloydspharmacy, Lee Avenue, Riddrie, GLASGOW, Lanarkshire, G33 2QX

Pharmacy reference: 1080653

Type of pharmacy: Prison / IRC

Date of inspection: 11/04/2019

Pharmacy context

The pharmacy is in the medical centre at HMP Barlinnie. It dispenses medicines for offenders in all seven prison halls. Dispensed medicines are collected by nursing staff and taken back to the halls. The nurses' mostly issue medication for self-administration, but also administer when required. Registered pharmacists and pharmacy technicians work in the pharmacy.

Overall inspection outcome

Standards not all 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 not all met	2.1	Standard not met	There is not enough assurance that staffing is at the right level to safely provide dispensing services. Nor that there is enough pharmacist cover to meet the responsible pharmacist regulations.
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 team members complete training and work to professional standards. But, not all the company's policies and procedures are in use. This means that the pharmacy team members may not always be providing services according to best practice. The pharmacy team has recently started to keep records of mistakes when they happen. And discuss the need for new safety measures. The pharmacy keeps the records it needs to by law. It understands its role in protecting vulnerable people. And keeps confidential information safe. People using the pharmacy can raise concerns. And staff know to follow the company's complaints handling procedure. This means that staff listen to people and put things right when they can.

Inspector's evidence

The responsible pharmacist had worked at the pharmacy for around two years. The responsible pharmacist notice was visible. And displayed the name and registration number of the pharmacist on duty. The pharmacist worked in the pharmacy part-time, and carried out prison visits the rest of the time. The prison visits had increased over the past few months. And from time to time, this meant that the responsible pharmacist was away from the pharmacy for more than 2 hours and more than the responsible pharmacist regulations legislated for. The responsible pharmacist record showed compliance with legal requirements. But, the responsible pharmacist stated this was because staff did not know how to record periods of absence. The pharmacy team signed to confirm they followed standard operating procedures. But, the pharmacy had annotated the Lloyds Pharmacy Provision of Pharmaceutical Services to the Scottish Prison Service procedure to 'not used in Barlinnie'. The implementation date was March 2010, and the revision date 2011.

The pharmacy team signed prescriptions to show they had completed a dispensing task. This included, assembly and accuracy checking prescriptions. The pharmacist checked prescriptions. And gave feedback to the pharmacy technician when she failed to identify her own errors. The pharmacy team had updated their knowledge of the near-miss procedure in February 2019. And the pharmacy technician recorded her near-misses. The level of recording was low. Which meant that improvement action was not always identified and discussed. The pharmacy team carried out self-audits to identify pharmacy risks. For example, in March 2019, the pharmacy team had been reminded to record near-misses. And to improve the quality of the records for the near-miss review at the end of the month.

The pharmacist had identified quantity and strength errors as a common theme. And distractions had been identified as the root cause. The pharmacy team had agreed to finish off dispensing tasks before responding to phone calls or queries at the door. In February 2019, the pharmacy team had agreed to discuss the need for access to the Lloyds e-learning module. But, the area manager had left the company, and they were unsure when a replacement would be recruited. The pharmacy team had documented they would discuss the significant workload increase. And the burden this placed on the pharmacy technician who dispensed on her own. The company had not carried out an external audit of the service during the past 18 months.

The pharmacy team were focussed on checking new prescriptions against the pharmacy records that

they kept. For example, an interim prescription for amlodipine 10mg was queried when medical staff had been prescribing 5mg. The pharmacist managed the incident reporting process. The pharmacy team knew when incidents had happened and what the cause had been. For example, they knew about a mix-up with melatonin and metformin. And knew to take greater care to avoid a re-occurrence in the future. The protecting vulnerable group scheme helped to protect children and vulnerable adults. And the company had registered the pharmacists. The pharmacy team had not completed safeguarding training. Even though they had occasional contact with offenders.

A complaints policy ensured that staff handled complaints in a consistent manner. This increased the likelihood of the pharmacy team being able to resolve issues. And managed the need for people to escalate complaints. For example, when health centre staff complained of medicine shortages. The pharmacy team contacted the Bellshill branch and arranged for ad-hoc deliveries.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge completed the responsible pharmacist record. The health centre was responsible for supplying and managing controlled drugs. The pharmacists had completed competent witness training. And this authorised them to check and verify controlled drug stock that was kept in the health centre. The pharmacy kept a small range of controlled drug stock. And checked and verified the balance on a regular basis. A sample of specials records were up to date. And the pharmacy team recorded the name of the person who had received the medication.

The pharmacy team completed data protection training during induction. The pharmacy disposed of confidential waste in designated containers. And once full they were sent to the Lloyds Bellshill branch for destruction. The pharmacy team archived spent records for the standard retention period. The pharmacy stored prescriptions for collection out of view of the waiting area. And computer screens were not visible. The pharmacy team took calls in private using a portable phone when necessary. The pharmacy team used individual passwords to restrict access to patient medication records. Public liability and professional indemnity insurance were in place.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not have the right number of suitably qualified pharmacy team members throughout the week. The company provides ongoing training. But, the pharmacy team members are unable to access it due to ongoing issues. And this means they may not be up to date with policies and procedures. The pharmacy team members support each other in their day-to-day work. They can speak up and suggest service improvements. They share ideas and learnings to keep services are safe.

Inspector's evidence

The pharmacy work-load had increased by almost 1000 items per month over the past year. But, the company had not increased the staffing levels. A full-time pharmacy technician dispensed all prescription items and three part-time pharmacists carried out clinical and accuracy checks. The pharmacists also carried out prison visits both locally and across Scotland. The pharmacy technician had worked at the pharmacy for 18 months. And knew what activities could and could not be carried out in the absence of the responsible pharmacist. The pharmacy technician could contact the off-site responsible pharmacist should it be needed.

A sister branch of Lloyds pharmacy provided support. The pharmacy was located in Bellshill. And provided off-site dispensing services to prisons across Scotland. A pharmacy technician provided holiday cover. And the branch provided dispensing support when the pharmacy was closed and when there were urgent requests.

Regular locum pharmacists were employed to provide cover when needed. And the prison contract pharmacist manager could be contacted at the Bellshill branch for support. The pharmacy team attended health centre meetings. And this ensured they stayed up to date and not isolated. The pharmacy did not use targets to drive performance. And the number of items dispensed had been increasing over the past year. The pharmacy did not use the corporate performance review process to develop staff. And the pharmacy team did not complete mandatory e-learning that was required across the company. This was due to problems logging on to the system.

The pharmacy team had completed prison induction training when they took up post. And included self-defence and key-handling procedures. The pharmacy team had recently completed training about cybercrime. The pharmacy team members raised concerns and provided suggestions for improvement. For example, the pharmacy technician had identified the need for more support on a Monday when the pharmacy closed at 2pm. And one of the pharmacists provided support and produced dispensing labels so that dispensing was up to date.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for patients to receive healthcare.

Inspector's evidence

The pharmacy maintained and cleaned the premises on a regular basis. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. Offenders received treatment in the medical centre. And a locked metal gate was used to secure the pharmacy and allow communication with health care professionals at the same time. Personal alarms protected the pharmacy team. And staff had been trained to respond to prison alarms. The pharmacy had allocated benches for the different dispensing tasks. And dispensed multi-compartment medicine devices on a separate bench.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays service information at the entrance to the pharmacy. It provides contact details to be used when the pharmacy is closed. And this ensures there is access to out-of-hours pharmacy services. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy dispenses multi-compartmental compliance packs. And supplies extra information to these people to support them to take their medicines. The pharmacy sources, stores and manages its medicines appropriately. And updates the pharmacy team about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

A Lloyds branch at Bellshill provided cover after the pharmacy closed. And included weekdays until 6.00pm and Saturdays until 1.00pm. An on-call rota was in operation when both pharmacies closed. And details were displayed on the pharmacy door for the prison medical staff to refer to. The pharmacists carried out clinical checks on the medicines Kardex used to prescribe medication. The nurses took a photocopy of the Kardex to the pharmacy when supplies were needed. And these were dispensed and collected at a later date. Most offenders managed and self-administered their own medicines. And the pharmacy team had little control over their work-load. The pharmacy team photocopied each Kardex and these were retained for future reference. For example, when interim supplies were requested. This ensured that errors were identified and corrected.

The pharmacists provided prescribing advice during support visits. For example, the reclassification of gabapentin and pregabalin and the new prescription requirements. And were currently liaising with the health board to arrange access to the prison's clinical records. The pharmacists made clinical interventions. For example, when co-codamol 15/500 had been prescribed and the prescriber had been advised to change to 20/500. And when a non-steroidal anti-inflammatory drug had been prescribed for some who was using salbutamol.

The dispensing space was adequate. And the pharmacy team had allocated benches for the various dispensing tasks. The pharmacy team dispensed and checked each hall individually. And placed in totes ready for collection. The pharmacy team used dispensing baskets. And kept prescriptions and medicines contained throughout the dispensing process. The pharmacy provided multi-compartment medicine devices for 2 people who needed extra support. The pharmacy team issued a form and offenders ticked when they required a patient information leaflet. Descriptions of medicines were provided on a backing sheet that was attached to the device. The pharmacy team kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers.

The pharmacy kept controlled drugs in a well-organised cabinet to avoid selection errors. The pharmacist held the keys to the controlled drug cabinets to restrict access. And placed the keys in a tamper proof bag. And secured at the end of the day. The pharmacists kept the keys to the pharmacy. And prison staff did not have access out of hours. The pharmacy team carried out regular stock

management activities. And highlighted short dated stock and part-packs. They monitored and recorded the fridge temperatures. And demonstrated that the temperature had remained between two and eight degrees Celsius. The pharmacy disposed of medicines waste in designated containers. And once full they were sent to the Bellshill branch for destruction.

The pharmacy team acted on drug alerts and recalls. And recorded the outcome, and the date they checked for affected stock. For example, they had checked stocks of chloramphenicol in April 2019 with none found. The pharmacy team knew about the safety risks associated with the use of valproate in women. And they knew about the pregnancy protection scheme. The pharmacy team knew about the falsified medicines directive. And although the company had installed a bar-code reader it was not in use.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services.

Inspector's evidence

The pharmacy did not need to use measures for measuring liquids. However, used triangles for counting tablets and capsules. Cleaning materials were available for hard surface and equipment cleaning. And hand washing solution was also available. The pharmacy sink was clean and suitable for dispensing purposes. Reference sources were available. For example, the current copy of the BNF was in use.

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.