General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Daynight Pharmacy Ltd, 93 Macklin Street, DERBY, Derbyshire, DE1 1JX

Pharmacy reference: 1105908

Type of pharmacy: Community

Date of inspection: 28/09/2022

Pharmacy context

This community pharmacy is located close to the centre of Derby and is opposite a medical centre. People who use the pharmacy are from the local community and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it provides other NHS funded services. The pharmacy team dispenses medicines into multi-compartment compliance packs for people to help make sure they remember to take them.

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 manages the risks associated with its services to make sure people receive appropriate care. There are written procedures available to help the pharmacy team to know how to work safely. They discuss their mistakes so that they can learn from them, and they make changes to stop the same sort of mistakes from happening again. The pharmacy team keeps people's information safe and they understand their role in supporting vulnerable people.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the activities of the pharmacy and the services provided. The SOPs had been prepared by the superintendent (SI) in March 2022 and uploaded to the pharmacy's computer system so they could be viewed from any of the SI's pharmacies. Training records were also on the pharmacy's computer system, and they could be viewed for every dispenser and pharmacist in the company. This gave the pharmacists reassurance about training if pharmacy team members worked in a different pharmacy to cover absence. Roles and responsibilities were highlighted within the SOPs. The newest dispensing assistants were yet to complete SOP training and they had not filled in the spreadsheet, the responsible pharmacist (RP) was aware of this and as it was part of their induction training they were due to read them.

The RP explained the process for recording and reviewing near miss errors but could not locate the near miss logbook during the inspection. The team gave examples of where stock had been separated using plastic dividers to ensure that different strengths or formulations of the same medicine were clearly separated and not selected in error during the dispensing process. The RP explained that as some members of the pharmacy team were new, and they often had work experience students at the pharmacy, she was extra cautious when accuracy checking. There was an SOP for dealing with dispensing errors and an example of an error investigation was seen, this included steps that had been taken to prevent a similar incident occurring in the future. The error had been thoroughly investigated and other healthcare professional involved in the person's care had been informed of the outcome. The error had involved a controlled drug and the RP was unsure whether the Accountable Officer had been informed and it was not recorded on the form, she agreed to check this and report if it had not already been done. Staff meetings were held to discuss errors so that the pharmacy team could discuss the error and what could be done to prevent a similar error occurring in the future.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A dispensing assistant correctly answered hypothetical questions related to high-risk medicine sales.

The pharmacy's complaints process was explained in the SOPs. People could give feedback to the pharmacy team in several different ways; verbal, written and online. The pharmacy team tried to resolve issues that were within their control and would involve the SI if they could not reach a solution. The RP had worked at the pharmacy for a few months and explained that she had received positive feedback from people using the pharmacy about the way that she communicated and counselled

people about their medicines.

The pharmacy had up-to-date professional indemnity insurance. The Responsible Pharmacist (RP) notice was clearly displayed, and the RP log met requirements. Controlled drug (CD) registers were in order and two random balance checks matched the balances recorded in the register. Patient returned CD's were recorded in a register and promptly destroyed. Private prescription and emergency supply records were seen to comply with requirements.

Confidential waste was stored separately from general waste and destroyed securely. The pharmacy team had their own NHS Smartcards and confirmed that passcodes were not shared. The RP had completed level two training on safeguarding. The pharmacy team understood what safeguarding was and how they would raise concerns. The pharmacy offered a Naloxone distribution service and actively promoted this service to people requesting the needle exchange service, as well as providing information about injecting safely and disposing of used works properly.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its main dispensing workload and the services that it provides. But recent staff changes and reliance on temporary staff means the team is inexperienced, which may make it less effective. The team members plan absences in advance, so the pharmacy has enough cover. They work well together in a supportive environment, and they can raise concerns and make suggestions.

Inspector's evidence

The pharmacy team comprised of the pharmacy manager (RP during the inspection), a pharmacist that worked evenings and weekends, a dispensing assistant, three trainee dispensing assistants and a home delivery driver that worked across two pharmacies. There were also work experience students that came to the pharmacy for short term placements. These placements were not long enough in duration for the person to be enrolled on an accredited training course. Holidays were requested in advance and cover was provided by other staff members as required. There were some basic pharmacy tasks that had not been completed and the RP said she thought this may be due to the pharmacy team not being experienced and not knowing that they required doing, for example, daily fridge temperature checking, stock had been put into the wrong places on the shelves and split packs had been put onto the shelves with inadequate labelling.

Staffing levels were regularly reviewed, and two trainee dispensing assistants had been recruited to replace other staff members. The pharmacy manager was relatively new to the pharmacy, after transferring from another of the company's pharmacies. The pharmacy manager had started a service dispensing for local care homes and had identified that another staff member was required to manage this additional workload, so a job vacancy was advertised. Staff were enrolled on training courses and whilst they could have training time during working hours, they preferred to do it at home where it was quieter.

The team worked well together during the inspection and were observed helping each other and moving from their main duties to help with more urgent tasks when required. Members of the team discussed any pharmacy issues with their colleagues as they arose and held regular huddles within the dispensary during quieter times, as well as meetings when there was something more important to discuss.

The pharmacy staff said that they could raise any concerns or suggestions with the pharmacy manager, operations manager or SI. The RP was observed making herself available to discuss queries with people and giving advice when she handed out prescriptions. Some targets were set for professional services and the RP said that whilst there were some targets that she was expected to meet, she was able to use her professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare services. The pharmacy team uses a consultation room for some services and if people want to have a conversation in private.

Inspector's evidence

The premises were smart in appearance and appeared to be well maintained. Any maintenance issues were reported to the operations manager. The dispensary was an adequate size, and an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the worktops. There was a private consultation room which was used by the pharmacists during the inspection. The consultation room was professional in appearance. The door to the consultation room remained closed when not in use to prevent unauthorised access. A private area was used for supervised consumption and for needle exchange services. Prepared medicines were held securely within the dispensary and pharmacy medicines were stored behind the medicines counter, so sales were supervised.

The dispensary was clean and tidy with no slip or trip hazards evident. The pharmacy was cleaned by the pharmacy team. The sinks in the dispensary and staff areas had hot and cold running water. Hand towels and hand soap were available. There was a cellar used for storing pharmacy consumables. The pharmacy had air conditioning and the temperature felt comfortable during the inspection despite the outside temperature being unseasonably warm. The lighting was adequate for the services provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. It generally manages its services and supplies medicines safely. The pharmacy obtains its medicines from licensed suppliers and stores them securely. But it does not regularly check its stock medicines so it cannot provide assurance that they are always kept in good condition. People receive appropriate advice about their medicines when collecting their prescriptions.

Inspector's evidence

The pharmacy had a small step from the pavement and a home delivery service was offered to people who could not access the pharmacy. The pharmacy staff referred people to local services when necessary. They used local knowledge and the internet to support signposting. The pharmacy team could communicate with people in English, Urdu, Punjabi and Arabic. This was particularly useful for the home delivery service as many of the people using the service did not speak English as a first language.

Items were dispensed into baskets to ensure prescriptions were not mixed up together. Different coloured baskets were used to prioritise certain prescriptions. Staff signed the dispensed and checked boxes on medicine labels, so there was a dispensing audit trail for prescriptions. Notes and stickers were attached to medication when there was additional counselling required or extra items to be added to the bag. The team were aware of the risks associated with the use of valproate during pregnancy, and the need for additional counselling. Patient cards and counselling materials were available.

Multi-compartment compliance packs were used to supply medicines for some patients. Prescriptions were ordered in advance to allow for any missing items to be queried with the surgery ahead of the intended date of supply. A sample of dispensed compliance packs was checked, and some had not been labelled with descriptions for every medication which meant individual medicines could be difficult for people to identify. And patient information leaflets (PILs) were rarely sent, which meant that people may not have all of the information they needed to take their medicines safely. The team used a common-sense approach when talking to people about changes to compliance packs and tried to do what was best for the patient.

The pharmacy advertised a smartphone app to support people in ordering their repeat medication. The local surgeries did not allow pharmacies to order on people’s behalf, so the SI had researched and paid for the app to help people order their own prescriptions. The app had the added benefit of allowing the pharmacy to see what the person had ordered and when. This allowed the pharmacy team to chase missing items with the surgery ahead of the person calling in to collect their prescription and to send messages and notifications to people about the status of their prescription request.

No out of date medicines were seen during the inspection. The date checking matrix showed that date checking had not taken place recently and the RP explained that the current team may not have thought to do date checking.

Medicines were generally stored in an organised manner on the dispensary shelves. There were some medicine bottles containing medicines that had been removed from their original packaging in error

that had been labelled with the name and strength of the medicine, but not the brand, batch number or expiry date. These were removed from the shelves and discarded when the inadequacy of the labels was pointed out. Most split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in designated bins. Medicines were obtained from a range of licenced wholesalers and the pharmacy was alerted to drug recalls via emails from head office.

The CD cabinets were secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. Fridge temperature records had not been recorded since July 2022 so the team could not provide assurance that the medicines in the fridges were stored between the required temperature range of 2°C and 8°Celsius, the temperature was showing as within the correct range during the inspection. The RP said this was a training need within the team that had been overlooked with the staffing changes.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. The team uses this equipment in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the BNF and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Separate measures were used for the preparation of methadone. Counting triangles were available. Computer screens were not visible to the public as members of the public could not access the dispensary. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.