General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Night Pharmacy, 4 Swan Island Shopping Precinct, Chase Road, BURNTWOOD, Staffordshire, WS7 0DW

Pharmacy reference: 1108268

Type of pharmacy: Community

Date of inspection: 09/07/2019

Pharmacy context

This is a 100-hour pharmacy, located in a small shopping precinct in a residential area of Burntwood. The pharmacy dispenses NHS prescriptions, provides weekly multi-compartment compliance packs for people in their own homes and delivers medicines to people who are housebound. The pharmacy offers several other NHS services including Medicine Use Reviews (MURs), and the New Medicine Service (NMS), as well as some local services including the management of minor ear, nose and throat conditions. Substance misuse treatment services are also available.

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 risks adequately and team members take some action to learn from their mistakes and improve patient safety. The pharmacy keeps the records it needs to by law, but some information is missing so team members may not always be able to show what has happened. Pharmacy team members understand how to keep people's private information safe and raise concerns to protect vulnerable people.

Inspector's evidence

A range of standard operating procedures (SOPs) covered operational tasks and activities. Some of the procedures had been recently updated and several training record sheets had been signed to confirm staff acknowledgment and understanding. But some records were incomplete which may mean that the pharmacy is not always able to show that all team members are aware of their roles and responsibilities. The pharmacy had professional indemnity insurance to cover its services.

Pharmacy team members recorded their near misses. There was a gap in near miss records between January 2019 and June 2019. It was unclear whether entries had not been recorded for this period or whether the records were archived elsewhere. The team reported that there may be some near misses which are not recorded. But they were able to discuss some changes that had been made in response to previous trends or incidents. No record of near miss reviews was maintained, so the team may not always be able to clearly demonstrate how they had learnt from incidents. A recent dispensing incident was discussed, this had been documented in line with company procedures and a root cause analysis had been completed. Several actions had been taken in response to help prevent the likelihood of the same mistake happening again.

The pharmacy team discussed their roles and duties and a medicine counter assistant (MCA) was able to discuss the activities which could and could not take place in the absence of a responsible pharmacist (RP).

The pharmacy had a complaint procedure. But this was not advertised so people may not always be aware of how a concern can be raised. People could provide feedback verbally and a few 'thank you' cards which had been received from patients were displayed in the dispensary. Additional feedback was provided through online reviews and the pharmacy also participated in a community pharmacy patient questionnaire (CPPQ).

The correct RP notice was conspicuously displayed, and the RP record was in order. Specials procurements records provided an audit trail from source to supply and emergency supply records were compliant. But records of private prescriptions did not always record the details of the prescriber in line with regulations. Controlled Drugs (CD) registers had recently moved to an online system and a running balance was maintained. Previous registers had been archived and were not available on the day.

Pharmacy team members completed information governance training and demonstrated an awareness of confidentiality. The pharmacy had a privacy notice displayed near to the medicine counter and confidential waste was segregated and shredded on the premises. Team members were in possession

of their own NHS smartcards, but they were not always kept as securely as they should be, which may increase the likelihood of unauthorised access.

Safeguarding guidance documents were available, and several team members had completed training through CPPE. A pre-registration pharmacist and an MCA discussed some of the types of concerns that might be identified and said referrals would be made to the pharmacist in charge.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members receive training for the jobs that they do. They complete some ongoing training to help them keep up to date. But they do not always get regular reviews and feedback, so they might not always identify gaps in their knowledge and receive enough support. Team members can raise concerns about pharmacy standards.

Inspector's evidence

On the day of the inspection, a locum pharmacist was present along with a pre-registration pharmacist, four trained dispensers and an MCA. The pharmacy employed two additional regular locum pharmacists, a pharmacy apprentice and several customer services assistants, none of whom were present. The environment within the pharmacy was busy, but team members managed the workload effectively and supported one another well by providing assistance with other tasks as needed. They reported that all dispensing was up to date and that there were no delays to supplies. Leave within the pharmacy was managed by a dispenser and restrictions were in place to maintain adequate levels of staffing. There were some periods of time where the pharmacist may be required to dispense and self-check prescriptions, which may increase the likelihood of a mistake.

An MCA was clear on her role and discussed the questions that she would ask to ensure sales of medicines were appropriate. Concerns were escalated to the pharmacist and the MCA was also aware of certain restrictions on sales of medicines such as pseudoephedrine-based preparations.

Pharmacy team members were trained for their roles. They completed some ad hoc training, such as reading pharmacy magazines and training materials which were received through the post but records of this were limited, so team members may not always be able to show how they keep their knowledge up to date. A dispenser was enrolled on the NVQ level three pharmacy technician programme and had taken on some additional managerial responsibilities, following the departure of the previous pharmacy managers. Training for this had been provided and the team explained that the pharmacy owner had previously conducted appraisals to monitor their development. The pre-registration pharmacist discussed the range of daily tasks she completed in the pharmacy. Any training had all been provided internally with no additional support from an exterior provider. There were no records of completed progress reports or development reviews being completed in line with GPhC pre-registration guidance. The pre-registration pharmacist spent a limited amount of time with the designated tutor, who was not present on the day.

An open dialogue was observed amongst the team. Informal meetings were held where any issues were discussed. The team said that concerns were referred to a dispenser and were also happy to contact management, if required. The locum pharmacist was not aware of any targets in place for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for the delivery of healthcare services.

Inspector's evidence

The pharmacy premises were reasonably well maintained. Team members carried out daily cleaning duties and the pharmacy appeared clean on the day. There was adequate lighting throughout and the temperature was appropriate for medicine storage.

The retail area was professional in appearance and the floor space was free from obstructions. Chairs were available for use by people less able to stand and an enclosed consultation room was available to facilitate private and confidential discussions. The consultation room was reasonably well maintained but it was compact which may cause some restrictions with access or service provision. The dispensary had an adequate amount of space for the current workload. Prescription baskets were stacked to try and create more space on work benches and a separate sink was available for medicines preparation, which was equipped with appropriate had sanitisers. Additional storage areas were in a reasonable state of repair.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are suitably managed and team members make some checks to help make sure that people on high-risk medicines know how to take them properly. The pharmacy sources medicines safely. But it could carry out more checks and keep better records to show that it stores medicines appropriately and makes sure that they are suitable for supply.

Inspector's evidence

The front entrance to the pharmacy had a single-step. No ramp facility was available, but the team said that assistance was offered to those who needed it. Additional adjustments were available for people with disabilities including large print labels to aid people with visual impairment. There was a limited amount of service promotion and some health promotion literature was displayed throughout the retail area. The team had access to resources to support signposting.

There was a defined workflow for dispensing. Baskets were used to separate prescriptions and help prevent medicines from being mixed up. Random checks demonstrated that 'dispensed' and 'checked' boxes were usually signed to record who was involved in the dispensing process. Prescription forms were not usually retained alongside medicines until the point of collection. This may mean that the team do not have access to important information at the time of supply and could increase the risk of a prescription being claimed in error. Stickers were available to highlight prescriptions for CDs but were not always consistently used, which may increase the risk of a supply being made after the prescription has expired. 'Pharmacist' stickers were used where additional counselling and monitoring was required but records to demonstrate this, such as audit trails of INR readings were not always kept. The team were aware of the risks of the use of valproate-based medicines in people who may become pregnant. And they had access to the necessary safety literature, which was discussed on the day.

The pharmacy kept audit trails of repeat prescription requests, including those for people on weekly multi-compartment compliance packs. The compliance packs were managed by a dispenser and the system appeared organised. Records were kept recording the details of any medication changes. Completed trays were labelled with patient details and had individual descriptions of medicines. Patient leaflets were not always supplied as they should be, which may mean that people do not always have access to the information they need to help take their medicines properly. Signatures were obtained to confirm the delivery of CDs, but an audit trail for general medication deliveries was not maintained. This may mean that the pharmacy is not always able to show what has happened in the event of a query.

The locum pharmacist discussed how people suitable for services such as MURs would be identified. Additional services including the treatment of minor ear, nose and throat conditions were available when the regular locum pharmacists were present. Local patient group directives (PGDs) to cover these services were available and consent forms were signed. There was some promotion for a travel vaccination service. This was not provided by the locum pharmacist on the day, and she was unsure as to whether the service was still operational at the time of the inspection.

Stock medications were sourced through reputable wholesalers and specials from a licensed manufacturer. Stock was reasonably organised, and the team kept some records to show that date checking was carried out, but they were not always fully complete. Short-dated medicines were

highlighted and no out-of-date medicines were identified from random checks. Out-of-date and returned medicines were disposed of in appropriate medicine waste bins. The pharmacy was not compliant with the European Falsified Medicine Directive (FMD), but team members discussed the action that was ongoing in order to become compliant. The team were aware of some of the ways in which alerts for faulty medicines and medical devices were received. Where stock was affected, a dispenser said that this was reported back to wholesalers. The team could not recall the most recent alert and audit trails were not routinely kept, so the team may not always be able to demonstrate that appropriate action has been taken.

CDs were stored appropriately with expired and returned CD segregated from stock. Random balance checks were found to be correct. The pharmacy fridge had a maximum and minimum thermometer and the temperature was checked and recorded daily. A second fridge, which was being used to store a small number of vaccinations was equipped with a thermometer, but the temperature was not being recorded, so the pharmacy cannot always demonstrate that medicines have been stored appropriately. The team agreed to review this, as the locum pharmacist had not been aware that medicines were being stored in the fridge. The temperature was within the recommended range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services safely.

Inspector's evidence

The pharmacy had access to several paper-based reference materials and internet access supported additional research. The equipment seen on the day was appropriately maintained. Several crown stamped glass measures were clean and separate measures were marked for use with CDs. Counting triangles were also available for counting loose tablets.

Electrical equipment was in working order. Computer systems were password protected and screens were located out of view to help protect privacy. Cordless phones enabled conversations to take place in private.

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.