General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Daynight Pharmacy Ltd, 41 Sherrard Street, MELTON MOWBRAY, Leicestershire, LE13 1XH

Pharmacy reference: 1116805

Type of pharmacy: Community

Date of inspection: 25/11/2024

Pharmacy context

This is a community pharmacy located on a busy main road in the centre of Melton Mowbray. It is open extended hours Monday to Saturday and most of its activity is dispensing NHS prescriptions. It also provides a prescription delivery service, the NHS Pharmacy First service, and it supplies medicines in multi-compartment compliance packs to some people. This was a targeted inspection and not all standards were looked at during this inspection.

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 not all met	1.1	Standard not met	The pharmacy has written procedures to support safe working. But it doesn't have adequate systems in place to make sure team members have read these and are following them in practice.
		1.6	Standard not met	The pharmacy does not keep adequate records about medicines that require secure storage, including patient-returned medicines. And it doesn't have the required signed patient group directions to support some of the services it provides.
		1.7	Standard not met	The pharmacy does not fully protect access to people's private information. It doesn't always dispose of confidential waste appropriately. And it does not adequately control the use of smartcards to prevent unauthorised access to NHS information.
2. Staff	Standards not all met	2.2	Standard not met	Some team members are not undertaking the required accredited training for completing dispensing tasks.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not always keep stock medicines in appropriately labelled containers. And it cannot show that it always manages medicines requiring safe custody, including patient-returned medicines, appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not fully manage the risks associated with its services. It does not keep adequate records about some medicines, including about patient-returned medicines. Patient Group Directions (PGDs) for the NHS Pharmacy First service have not been signed by either the pharmacists providing the service or by the authorising manager. The pharmacy does not fully protect access to people's private information. And some team members undertake tasks in the dispensary without the required training. It has written procedures to help team members work safely. But these are not always followed in practice which limits their effectiveness. Mistakes that happen during the dispensing process are sometimes recorded. But the reviews of these are limited which could mean opportunities to learn and improve from these events are missed.

Inspector's evidence

There was a Responsible Pharmacist (RP) notice displayed at the counter area where people visiting the pharmacy could see it. This notice displayed the details of the RP on duty at the time of the inspection. The RP record was available. Entries since the start of September 2024 were viewed and contained details for an RP for each day the pharmacy was open.

The pharmacy had a range of written standard operating procedures (SOPs) available for team members to refer to. The commencement date for those looked at was in 2024. There was evidence that some of the team members had read SOPs relevant to their roles, but the RP had not yet read all of the current SOPs. There was also evidence that procedures were not always followed. For example, not all dispensing labels were initialled to create an audit trail to show who had undertaken various parts of the activity. And controlled drug (CD) balance checks were not undertaken as regularly as set out in the corresponding SOP. There was an SOP covering dealing with dispensing errors. The RP was not familiar with the process. When asked, the RP explained that errors they were aware of had been recorded in the near miss record book. The records viewed contained very little information to show the events had been reviewed fully to understand how the error had happened and actions taken to prevent a similar event from occurring in the future. The RP said however that information was shared with the team to help raise awareness and that they would try to make sure the patient received the correct medicine promptly.

CD registers were available at the pharmacy. Most of the headings in the registers had not been completed, increasing the possibility of making entries in the wrong register. The dates entered for receipts and supplies were largely incomplete as they did not include the year. Some entries for receipts did not show who the stock had been obtained from. And there was evidence that entries had to be corrected on several occasions as a result of duplicate entries, missed entries, and entries in the wrong register. However, where corrections had been made, these were largely done in accordance with legal requirements to provide an audit trail. The physical stock of several solid dose forms was checked against the recorded balance, and these were found to agree. However, there were unexplained discrepancies between the recorded balance and physical stock of a methadone preparation. The pharmacy had a separate book to record patient-returned CDs. Records indicated some destruction had taken place, but the record did not show who had undertaken this activity. There were also entries made more recently for returned items which did not show they had been destroyed but the

corresponding medicines couldn't be found.

The pharmacy had hard copies of the patient group directions (PGDs) for providing NHS Pharmacy First consultations and treatments. But these had not been signed by either the RP (who said they had provided parts of this service at this pharmacy) or by an authorising manager. The RP explained the training they had done to offer parts of the Pharmacy First service and this had included training on use of an otoscope. The RP said they did not provide seasonal flu or Covid vaccinations.

Members of staff asked could explain what they could and couldn't do if there was no pharmacist present. They could also explain the types of over-the-counter medicines that could be misused and the extra care they took when selling these medicines.

There was no confidential information visible to people visiting the pharmacy; prescriptions were stored out of sight in the dispensary. Confidential waste was said to be separated from other waste so it could be disposed of securely. However, there was some confidential waste that had not been destroyed by other means found in the normal bin. NHS smartcards and associated passwords used to access the NHS spine were not well controlled. A smartcard belonging to a pharmacist not present had been left unattended in the open consultation room and passwords were displayed on the computer terminal nearby. In addition, the smartcard still in use in the dispensary belonged to a member of staff who had finished their shift and had left the pharmacy.

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

Summary findings

Not all members of the pharmacy team are doing the required training the tasks they undertake. But there appear to be enough staff members to cope with the workload.

Inspector's evidence

The RP at the time of the inspection was a locum pharmacist who worked at the pharmacy around three full days per week. According to the RP record and information from the pharmacy team, another locum pharmacist provided RP cover on the other three days. The team appeared to be able to cope with the workload during the inspection and team members were observed discussing queries with each other throughout the visit.

There were several other members of the team present during the inspection. One team member was completing an accuracy checking dispenser course. Other team members present were enrolled on medicine counter assistant courses though appeared to be taking longer to complete these than might have been expected. When asked about their usual activities, these other team members said they undertook some dispensing tasks including picking medicines against prescriptions and, in some case, creating dispensing labels. This activity was observed happening at the start of the inspection. None of these team members were enrolled on accredited dispenser training courses.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are adequate for providing services. And people can have a conversation in private with pharmacy team members.

Inspector's evidence

The premises were reasonably well maintained and there was a section of dispensing bench reserved for accuracy checking by the pharmacist. Preparation of multi-compartment compliance packs was done in a separate area of the dispensary which was quieter so less risk of distraction. The shop floor area was small but there was space for people waiting to be served. Pharmacy-only medicines were generally kept behind the medicine counter and the dispensary was not accessible to members of the public. There was a small, basic consultation room located off the retail area which was used for providing services including seasonal flu vaccinations. The room was equipped with seating, a table and access to patient medication records.

Lighting and ambient temperatures in the pharmacy were suitable for safe working. Staff had access to hygiene facilities.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy cannot show that it always manages its medicines safely. It does not always keep stock medicines in appropriately labelled containers. And it cannot show that it always manages medicines requiring safe custody, including patient-returned medicines, appropriately. But it does have processes in place to date check stock medicines to minimise the risk of these being supplied to people.

Inspector's evidence

CDs requiring safe custody were stored in the CD cabinet and access to the cupboard was controlled by the RP at the time of the inspection. There were some date-expired and patient-returned CDs stored at the bottom of one of the CD cabinets, but these were not clearly marked as such. Other medicine waste was placed in designated waste sacks, stored separately, and was collected for secure disposal; a collection occurred during the inspection. One small plastic bottle bearing a dispensing label which appeared to be a patient return was found at the start of the visit on a shelf in the rear of the premises next to staff food stuffs and not with other patient returned medicines. Photographs were taken of this. When the inspector looked towards the end of the inspection, the bottle was no longer in the same place. When asked, none of the staff present could explain where it was or if it had been disposed of but had been aware of its presence, saying it had been there for a while.

There were records showing daily maximum and minimum fridge temperatures for both of the pharmacy fridges. The records viewed indicated the temperatures were kept within the required range and a check conducted during the inspection found the same. There was enough storage capacity in the fridges for medicines. But food stuffs were also kept in one of the medicine fridges.

A spot check of expiry dates of medicines in the dispensary was conducted. All but one of the medicines checked were in date; the one that was date-expired had already been marked to highlight the expiry date, thereby reducing the risk of supply. However, there were several examples found of cartons which contained multiple brands of medicines with different batches/expiry dates. There were also loose blisters on the dispensary shelves. Not storing medicines in their original containers or in appropriately labelled containers increases the chance of mistakes happening and reduces the pharmacy’s ability to date check medicines effectively.

When asked, the RP did not know what process the pharmacy had for dealing with drug alerts and recalls. This could increase the chance that safety alerts are not acted on promptly.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's team members have access to the equipment they need to provide services safely.

Inspector's evidence

Patient information on computer screens was not visible from the shop floor. Medicine containers were capped to prevent contamination. The pharmacy had appropriate receptacles for storing sharps waste generated by vaccination services and it had a kit for denaturing CDs. The medicines fridges provided adequate space for storing medicines and there was enough secure storage space for CDs. Team members had access to online reference sources to help with providing advice to people. There were calibrated measuring cylinders available for liquid medicines; one was reserved for CDs to prevent cross-contamination.

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.