

# Registered pharmacy inspection report

**Pharmacy Name:** Daynight Pharmacy Ltd, 35 Furlong Road, Tunstall,  
STOKE-ON-TRENT, ST6 5TZ

**Pharmacy reference:** 1117107

**Type of pharmacy:** Community

**Date of inspection:** 18/06/2024

## Pharmacy context

This extended hour pharmacy is located on a busy main road, opposite a health centre in Tunstall, Stoke-On-Trent. Its main activity is dispensing prescriptions, and it offers some services such as the supervised consumption of medicines and the New Medicine Service. A medicine delivery service is available, and the pharmacy supplies some people with medicines in multi-compartment compliance to help them take their medicines.

## 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
<b>1. Governance</b>	Standards not all met	1.2	Standard not met	Team members do not effectively review or make a record of their mistakes. This means they miss out on opportunities to learn and improve the way services are provided.
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards not all met	4.3	Standard not met	Cold chain medicines are not always stored appropriately. The pharmacy cannot show that the fridges it uses to store medicines maintain temperatures within the recommended range.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance Standards not all met

### Summary findings

The pharmacy does not always adequately identify the risks associated with the services that it provides. Its team members do not complete reviews or make records of when things go wrong and so they may not identify ways to improve the services they deliver. And they miss out on opportunities to learn from their mistakes. The pharmacy keeps and maintains the records it needs to by law. Members of the team take the correct steps to protect people's private information and they know how to safeguard vulnerable people.

### Inspector's evidence

The pharmacy had a process to record mistakes that had been identified during the accuracy checking process, known as near misses. However, its team members had not recorded any near misses since January 2024 and the recording of mistakes was infrequent before then. There was no evidence of near misses being reviewed and the pharmacy team could not give any clear examples of steps taken to try and reduce mistakes from happening again. The lack of recording and reviews meant that team members not only missed out on opportunities to learn from their mistakes. There were no recent examples of dispensing errors occurring which is when a mistake is identified after a medicine has been supplied to the person. The responsible pharmacist (RP) explained that dispensing errors are recorded on an incident form and shared with the superintendent pharmacist (RP) when they occur.

A set of standard operating procedures (SOPs) that covered most of the services provided were kept electronically, and the majority of the team members had signed them to show they had read and accepted them. Procedures that covered some activities, such as the assembly of multi-compartment compliance packs, were not available. This means team members may not know the correct process to follow when dispensing medicines into the compliance packs. And the delivery driver had not signed any of the SOPs relating to the delivery of medicines. This means they may not follow the correct processes to fulfil their role safely. An assurance was provided that they had read SOPs and received some verbal training when they first joined the pharmacy team. The SOPs were due for review in March 2024 but there was no indication that this was being completed.

The pharmacy kept the records that it needed to by law. The private prescription record, emergency supply record, unlicensed medicines 'specials' record, responsible pharmacist (RP) record and the controlled drug (CD) registers were in order. Records of CD running balances were kept for most CD stock. Running balances for some liquid medicines were not maintained which meant it may make it harder for team members to identify any discrepancies in a timely manner. And the running balances were not always checked frequently to help make sure it matched the physical stock being held. Some balances were checked against the physical stock, and one was found to be incorrect. The RP investigated the discrepancy and was able to correct the balance. Patient returned CDs were recorded and disposed of appropriately.

An information governance policy or SOP was not available. Team members were not aware of signing a confidentiality agreement when commencing their employment. However, they were able to correctly explain the steps they took to protect people's private information. For example, they separated confidential waste and kept it secure before it was shredded in the pharmacy. And they stored

confidential information in a way so that it was not visible to people using the pharmacy.

The RP had completed formal safeguarding training and one of the team members had completed training with a previous employer. Training on safeguarding was not routinely provided to all team members but they were able to identify the signs that would indicate a safeguarding concern and explained that they would use the consultation room for discretion and refer to the pharmacist. Contact details for the local safeguarding team was available.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to provide its services in an effective manner. It provides support to members of the team who are enrolled on training courses. Members of the team feel comfortable to raise concerns and provide feedback.

### Inspector's evidence

The pharmacy team consisted of a regular locum pharmacist, six trainee dispensing assistants and one delivery driver. There were also two additional team members who were employed to keep the pharmacy clean, tidy and help with basic administration tasks such as cashing up. Two other regular locum pharmacists were also used to cover the opening hours of the pharmacy. Team members who were working towards a suitable qualification were enrolled on to an accredited training course for the roles they fulfilled. And assurance was provided that the delivery driver had completed some training when they were first employed.

Members of the team in the dispensary were aware of their roles to help manage the workload effectively. Team members explained the questions they would ask when selling pharmacy medicines. And they identified medicines that are liable to misuse. In such cases, they would refer to the pharmacist if they felt the sale was inappropriate or if repeated requests were made. The pharmacy team members were seen working well together and they supported each other as people entered the pharmacy during busy periods.

The pharmacy completed annual appraisals with its team members to discuss how they had performed and to help identify any future training needs. But there was no structured ongoing training in place once team members had qualified for their role. This may mean that any new learning opportunities are missed.

Informal team meetings were held to discuss pharmacy related topics and to help prioritise workload. Members of the team felt comfortable raising concerns or providing feedback to the RP. Some targets were set by head office, but the RP explained that it did not affect their professional judgement.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's environment is suitable for the services that it provides. It is generally clean and tidy, but some areas are cluttered which detract from its professional appearance. A consultation room is available for the confidential provision of pharmacy services.

### Inspector's evidence

The pharmacy was clean and well-lit. It had central heating to help maintain the room temperature at a suitable level. Its team members cleaned the pharmacy daily. The pharmacy had adequate bench space to assemble prescriptions. But some work surfaces were cluttered which made it more difficult for team members to always work effectively and efficiently. A clean sink with hot and cold running water was available and was suitable for preparing medicines that required mixing before being supplied to people.

The pharmacy had a consultation room available for people to have private conversations or receive pharmacy services. The consultation room was adequate in size for the services that the pharmacy offered. The dispensary area was situated behind the front counter and unauthorised access was restricted. Suitable staff facilities were available which included a small kitchen area, washroom and rest area. The pharmacy was secured when closed.

## Principle 4 - Services Standards not all met

### Summary findings

Overall, the pharmacy provides the services it offers in an effective manner. The pharmacy gets its medicines and devices from appropriate sources. But it does not always store medicines requiring cold conditions appropriately. So, it may not be able to demonstrate that they are safe to use. Members of the team are not always aware when higher risk medicines are being supplied, so they may not always provide additional advice to people to help make sure they use their medicines safely.

### Inspector's evidence

There was a step at the entrance of the pharmacy which made it difficult for people with mobility issues or those with a wheelchair to enter. Team members explained they assisted people that required a service and referred them to another local pharmacy or healthcare provider if they were unable to help. The opening hours of the pharmacy were displayed on the entrance door. A range of health information leaflets were situated in the retail area for people to access if they required additional health related information.

The pharmacy obtained its medicines from licensed wholesalers and unlicensed specials were ordered from a specials manufacturer. Stock medicines were largely stored tidily. The RP explained that short-dated medicine stock was usually marked with a pen so that it can be easily identified during the dispensing process. However, some short-dated stock did not have any markings to show this. The expiry dates of medicine stock were checked every six months. A random selection of stock was checked, and some medicines were found to be out of date. The RP disposed of these medicines when it was highlighted to them. Controlled drugs were appropriately stored in a locked cabinet.

There were two medicine fridges available which were clean and equipped with portable thermometers. But the fridges were not medical grade, and the temperatures of both fridges were seen to have exceeded the recommended 2-8 degrees Celsius range. The maximum and minimum temperatures were recorded daily but it did not reflect the actual temperatures. The actual temperature of the fridges when checked were 19.4 and 19.8 degrees Celsius. This was highlighted to the RP who explained new thermometers had recently been installed and provided an assurance that it would be investigated and that they would periodically check the temperature to make sure it fell back into range. Waste medicines were disposed of in dedicated bins that were collected periodically by a specialist waste contractor. Drug alerts and recalls were received electronically, and records were kept but they didn't show what action, if any, had been taken. So, it may make it harder to respond to a query following an alert.

The pharmacy provided some NHS services including the New Medicine Service. Volumes of these services were low. A supervised consumption service of higher risk medicines was in operation. People consumed their medicines in the consultation room for privacy if there were people waiting in the retail area of the pharmacy.

NHS prescriptions were received electronically, and dispensing baskets were used to keep individual prescriptions separate to avoid medicines being mixed up during the dispensing process. Dispensed medicines awaiting collection were bagged and stored securely away from unauthorised access. The pharmacist attached stickers to the bags to highlight when controlled drugs or fridge lines needed to be

added. This also acted as a prompt for team members to check the validity of CD prescriptions before being supplied to people. Prescriptions for schedule 3 and 4 CDs were also marked so that the date on the prescription could be checked to reduce the risk of a medicine being supplied against an invalid prescription. A sticker was attached to the top of a prescription to highlight when counselling by the pharmacist was needed. A dispenser explained how they always asked people to confirm their names and addresses before medicines were handed out, to make sure they were supplied to the correct person. Some people had their medicines delivered to their homes and a record of the successful deliveries was maintained. The delivery driver requested a signature when a CD was delivered which was in line with the written procedures.

The RP was aware of the risks associated with the use of valproate during pregnancy. The pharmacy did not currently have any patients who met the risk criteria, but the pharmacist knew that such patients should be counselled. The pharmacy team knew that valproate should always be supplied in original packs and knew how to attach dispensing labels to avoid covering important information. Other higher risk medicines were not routinely highlighted which meant team members were not prompted to provide additional advice to help make sure the medicine was being taken safely.

The pharmacy supplied medicines in multi-compartment compliance packs to people that required support with taking their medicines correctly. A dispenser explained that they ordered people's prescriptions using the 'repeat slip' which is then sent to the GP. A record of the medicines ordered is retained and the new prescriptions are checked against this record. Any discrepancies were checked with the surgery and any changes to medicines were recorded on the person's patient medication record (PMR). Compliance packs were routinely left unsealed, but covered to avoid contamination, after they had been assembled as the RP felt it was easier for them to complete an accuracy check. They explained that they had assessed the risk of leaving them unsealed and assigned a clear workspace for them to be stored. Team members only included the description of medicines on the first weekly pack. This meant that people may not be able to easily identify their medicines contained within the other three weekly packs. The risk of this was discussed with the team and the RP provided an assurance that this would be rectified. Patient information leaflets were routinely supplied so people could access additional information if needed.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide the services that it offers. And its facilities help its team members provide services in an effective manner.

### Inspector's evidence

The pharmacy had a selection of clean calibrated glass measures to help its team members measure liquid medicines. And it clearly marked measures that were used for higher risk medicines to prevent cross-contamination. Clean counting equipment was also available for tablets and capsules. The pharmacist explained they used the internet to access resources such as the British National Formulary (BNF).

The pharmacy had two computer systems installed which held people's medication records. The screens were not visible to members of the public and the computers were password protected to prevent unauthorised access. Members of the team used cordless phones so they could have conversations without being overheard by people.

### 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.