General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: T H Dolman Ltd, 9 Linkfield Corner, REDHILL, Surrey, RH1 1BD

Pharmacy reference: 1036725

Type of pharmacy: Community

Date of inspection: 06/06/2023

Pharmacy context

This is an NHS community pharmacy on a small parade of shops in Redhill. The pharmacy opens six days a week. It sells medicines over the counter. And it dispenses people's prescriptions. The pharmacy delivers medicines to a few people who have difficulty in leaving their homes. It provides a substance misuse treatment service. And it supplies multi-compartment compliance packs to a handful of people who need help managing 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
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy doesn’t manage its risks appropriately. And the way its team works and stores its medicines increases the risk of mistakes happening. The pharmacy has some written instructions to help its team members work safely. But these aren’t reviewed regularly and aren’t always followed.
		1.2	Standard not met	The pharmacy doesn’t adequately review the services it provides when things go wrong. And, for example, it doesn't keep records of the dispensing mistakes it makes, nor the steps its team takes to stop the same sort of things happening again.
		1.6	Standard not met	The pharmacy is required to keep certain records by law. But these aren’t always filled in correctly. And, in the case of its controlled drug records and private prescription register, aren't available at the pharmacy.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is very cluttered and disorganised particularly in areas people using its services can’t see. And this could present an unacceptable risk to the health and safety of the people who visit or work at the pharmacy.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	People who work at the pharmacy don’t follow the pharmacy procedures all the time. The pharmacy doesn’t keep adequate records to show its working practices are safe and effective. It can’t show it has supplied the right medicine to the right person. And it doesn’t always give people the information they need to make sure they take their medicines properly.
		4.3	Standard not met	The pharmacy doesn’t suitably store all its medicines that must be locked away or those that it needs to keep in a refrigerator.

Principle	Principle finding	Exception standard reference	Notable practice	Why
5. Equipment and facilities	Standards not all met	5.2	Standard not met	The pharmacy has a small refrigerator to keep medicines in that require refrigeration. But this is too small and isn't fit for purpose or appropriately maintained.

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

Summary findings

The pharmacy doesn’t manage its risks appropriately. It doesn’t adequately review the services it provides when things go wrong. And the way its team works and stores its medicines increases the risk of mistakes happening. The pharmacy has some written instructions to help its team members work safely. But these aren’t reviewed regularly and aren’t always followed. The pharmacy has the insurance it needs to protect people. And it’s required to keep certain records by law. But these aren’t always filled in correctly and aren't available at the pharmacy. People who work at the pharmacy generally know what they can and can’t do. They try to keep people’s private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for some of the services it provided. But these hadn’t been reviewed for several years. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and agreed to stick to them. But they hadn’t signed most of them, and they didn’t always follow them. The pharmacist was the only pharmacy team member who dispensed people’s prescriptions. And they were solely responsible for assembling and checking people’s prescriptions. But they didn’t initial each pharmacy label as required by the SOPs to show they had dispensed a prescription. And several prescriptions awaiting collection hadn’t been put into dispensing bags as required by the SOPs. The pharmacy had very limited space for its team to dispense people’s prescriptions in. It was cluttered and disorganised. Its consulting room, corridors, counter, dispensary, stairs, stockroom, worksurfaces and some public-facing areas were obstructed by boxes or carrier bags containing paperwork, sundries or stock. And this presented a significant risk to the health and safety of the people who visited or worked at the pharmacy. The pharmacy had a process to deal with people’s complaints. It also had a procedure to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren’t (dispensing errors). And the SOPs required the pharmacy team to record these events, the lessons it learnt from them and the actions it took to try and stop the same sort of things happening again. But there weren’t any records of recent dispensing mistakes or complaints made about the pharmacy or its team. The pharmacist explained that they hadn’t made a mistake for quite some time as they were very careful when they dispensed people’s prescriptions. But they described an undocumented mistake which led them to separate escitalopram (a medicine used to treat depression) and esomeprazole (a medicine used to treat acid reflux, heartburn and indigestion) from one another on the shelving in the dispensary. People had shared their experiences of using the pharmacy and its services on the internet.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It displayed a notice that told people who the responsible pharmacist (RP) was at that time. And its team members knew what they could and couldn’t do, what they were responsible for and when they might seek help. But their roles and responsibilities weren’t clearly described within the SOPs. The pharmacy kept a record to show which pharmacist was the RP and when. But the pharmacist had already completed the record to show they were the RP for the next four days. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. But when the pharmacy received an unlicensed medicinal product, when it supplied it and who it supplied it to weren’t routinely recorded. The controlled drug (CD) register and the private prescription register weren’t available at the pharmacy at the time of the inspection. The pharmacist explained they had

removed these registers and taken them home as they hadn't made some entries and needed to update them. The pharmacist also explained that the pharmacy didn't supply prescription-only medicines to people in an emergency. People using the pharmacy generally couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy had an information governance policy. And its team needed to complete a self-assessment each year and declare to the NHS that it was practising good data security and it was handling personal information correctly. The pharmacist gave assurances that confidential information was appropriately disposed of. The pharmacy had safeguarding procedures. And its team knew what to do or who it would make aware if it had a concern about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just enough people to deliver its services. But its team members are sometimes so busy they struggle to do all the things they need to do. Members of the pharmacy team use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy team consisted of a pharmacist and a part-time team member. The pharmacist gave an assurance that the part-time team member would be put on an accredited training course relevant to their role. This was because the team member had worked at the pharmacy for nearly three months. The pharmacy struggled to find cover when team members were off. And it had a vacancy for another part-time team member. But it was finding it hard to fill this vacancy. Members of the pharmacy team sometimes found it difficult to do all the things they needed to do as they didn't always have enough time to do them. So, they stayed behind after work to keep on top of the workload. People sometimes had to wait a little longer than usual when using the pharmacy. This could be frustrating for them particularly when the pharmacy team was already dealing with other people, prescriptions or enquiries. The pharmacist was the superintendent pharmacist and the pharmacy's regular RP. They were responsible for managing the pharmacy and its team. They supervised and oversaw the supply of medicines and advice from the pharmacy. The pharmacy had a sales-of-medicines protocol. And this described the questions people should be asked, and when they should be referred to a pharmacist. The pharmacy didn't have any incentives or targets. Its team felt able to make decisions that kept people safe. And, for example, the pharmacy tried to keep certain hormone replacement treatments in stock that people couldn't get from other pharmacies. The pharmacist was required to keep their professional skills and knowledge up to date as part of their annual revalidation process. Members of the pharmacy team could ask the pharmacist questions and familiarise themselves with products when they had the time to do so. They knew who they should raise a concern with if they had one. They could make suggestions on how to improve the pharmacy and its services. And, for example, a small plastic screen was put on the counter following their feedback to try and stop the spread of coronavirus.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is very cluttered and disorganised particularly in areas people using its services can't see. And this could present an unacceptable risk to the health and safety of the people who visit or work at the pharmacy. The pharmacy is large enough for the services it provides. And is adequately presented in the areas people using its services can see.

Inspector's evidence

The pharmacy was air-conditioned, bright and secure. Its public-facing area was adequately lit and presented. And its team members were responsible for keeping its premises clean and tidy when they got time to do so. The pharmacy was very cluttered and disorganised. It didn't have a clear dispensing workflow or any empty workbench space. And its corridors, counter, dispensary, stairs, stockroom, worksurfaces and some public-facing areas were obstructed by boxes or carrier bags containing paperwork, stock or sundries. These things presented a hazard to the health and safety of those who used or worked at the pharmacy. The pharmacy had a consulting room. And it had some sinks and a supply of hot and cold water. But people couldn't use the consulting room as its entrance was obstructed by several cardboard boxes. And its floor was congested with bags containing paperwork and other sundry items.

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

Summary findings

People who work at the pharmacy don't follow the pharmacy's procedures all the time. The pharmacy doesn't keep adequate records to show its working practices are safe and effective. It can't show it has supplied the right medicine to the right person. And it doesn't always give people the information they need to make sure they take their medicines properly. The pharmacy doesn't suitably store all its medicines that must be locked away or those that it needs to keep in a refrigerator. The pharmacy generally sources and manages its other medicines appropriately. It usually carries out checks to make sure these medicines are safe and fit for purpose. It can get rid of the medicines that people no longer want or need. And people can access its services.

Inspector's evidence

The pharmacy didn't have an automated door. And its entrance wasn't level with the outside pavement. So, people who couldn't open the door easily, such as people with pushchairs or wheelchairs, relied upon other people or the pharmacy team to help them access the pharmacy. The pharmacy had a notice that told people when it was open. And it had a chair next to its entrance for people to use when they wanted to wait in the pharmacy. The pharmacist tried to be friendly and help people throughout the inspection. They knew where to signpost people to if a service wasn't available at the pharmacy. And they took the time to talk to people about their medicines especially when a new medication had been prescribed. But queues of people developed quickly as the pharmacist could only deal with one person or task at a time. This meant that people had to wait some time or return later to collect their medication or talk to the pharmacist. The pharmacy provided a delivery service to a handful of people who couldn't attend its premises in person. But it didn't keep a record of the deliveries it made as required by its SOPs. So, it couldn't show it had delivered the right medicine to the right person. The pharmacy didn't keep an audit log of who assembled and checked each prescription as required by its SOPs. And the pharmacist generally dispensed prescriptions or outstanding medication only when people attended the pharmacy. The pharmacy used a disposable and tamper-evident system for people who received their medicines in multi-compartment compliance packs. It provided a brief description of each medicine contained within the multi-compartment compliance packs. But it didn't provide any patient information leaflets despite its SOPs requiring its team to do so. So, people didn't have all the information they needed to make sure they took their medicines properly or safely. The pharmacy didn't mark the CD prescriptions it had with the date the 28-day legal limit would be reached. And this meant there was a greater risk of its team making supplies that were unlawful. The pharmacist was aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed valproate needed to be counselled on its contraindications.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept most of its medicines and medical devices within their original manufacturer's packaging. But a few medicines weren't. And an unlabelled container of some unknown capsules was found in the dispensary. Members of the pharmacy team checked the expiry dates of medicines as they dispensed them or when they got chance to. But they didn't record when they had done so as required by the pharmacy's SOPs. And an expired antibiotic was found amongst in-date stock during the inspection. This was removed when brought to the attention of the pharmacist. The pharmacy routinely rinsed out large plastic containers and used them again later when larger volumes of liquid medication needed to be

dispensed. But its team didn't always remove the manufacturer's label. And this meant there was a risk of people being given medication with a different batch number and an expiry date to the one on the container. The pharmacy didn't store its stock, which needed to be refrigerated, at an appropriate temperature and the refrigerator was below freezing. And some boxes of an injectable prescription medicine used to improve blood sugar that required refrigeration weren't stored in the refrigerator as it was full. The pharmacy didn't store all its CDs, which weren't exempt from safe custody requirements, securely as it didn't have space to do so. It had allowed out-of-date CDs to build up. And no records were seen for the destruction of the CDs that people returned to it. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And it had some pharmaceutical waste bins. But waste medicines weren't always kept separate from the pharmacy's stock. The pharmacy had removed and returned its pholcodine-containing cough and cold medicines following a medicines recall issued by the Medicines and Healthcare products Regulatory Agency (MHRA) explaining that these products were to be withdrawn. The pharmacist described the process they followed when dealing with a recall issued by the MHRA. But the pharmacy hadn't kept a record of any recent recalls or the actions it took in response to these.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

The pharmacy has a small refrigerator to keep medicines in that require refrigeration. But this is too small and isn't fit for purpose or appropriately maintained. Otherwise, the pharmacy generally has the equipment and the facilities it needs to provide its services. And its team usually makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had some glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team usually cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had an old refrigerator to store pharmaceutical stock requiring refrigeration. But this was small, and the ice box required defrosting. And a plastic covering was placed over the stock in the refrigerator and a broom was used to keep the refrigerator door shut. The pharmacy team was required to check and record the refrigerator's maximum and minimum temperatures on the days the pharmacy was open. But this hadn't been done for a few weeks. And, at the time of the inspection, the thermometer indicated that the maximum and minimum temperatures of the refrigerator were outside of the appropriate range. The pharmacy restricted access to its computer and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screen so it could only be seen by a member of the pharmacy team. But it could do more to make sure its team members stored their NHS smartcards securely when they weren't working or using them.

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.