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: 25/04/2024

Pharmacy context

This is a re-inspection of an NHS community pharmacy. The pharmacy is on a small parade of local shops and businesses in Redhill. And it opens six days a week. The pharmacy dispenses prescriptions. And it sells medicines over the counter. The pharmacy supplies multi-compartment compliance packs to a few people who need help managing their medicines. And it provides support for people who use drugs.

Overall inspection outcome

Standards not all met

Required Action: Statutory Enforcement

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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.
		1.4	Standard not met	The pharmacy doesn't take the action it needs to in response to feedback from organisations such as the General Pharmaceutical Council.
		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 private prescription register and most of its controlled drugs records, aren't available at the pharmacy.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy doesn't have enough team members to deliver its services safely and effectively. And its team struggles to do all the things it needs to do and is behind with its work.
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. And it can't show it has supplied the right medicine to the right person.
		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.
5. Equipment	Standards	5.2	Standard	The pharmacy has a small refrigerator to

Principle	Principle finding	Exception standard reference	Notable practice	Why
and facilities	not all met		not met	keep medicines in that require refrigeration. But this isn't big enough, fit for purpose or appropriately maintained. And the pharmacy team doesn't use the equipment properly to check the temperature range is as it should be.

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

Summary findings

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. The pharmacy doesn't do enough to make sure it keeps records in the way the law requires it to do so. And it doesn't take the action it needs to in response to feedback from the General Pharmaceutical Council (GPhC). 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 know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for some of the services it provided. But most of them hadn't been reviewed for several years despite the superintendent pharmacist providing an assurance they would be at the last inspection. 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 didn't always follow them. The superintendent 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 work in. It was cluttered and disorganised. Its consulting room, corridors, counter, dispensary, 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 recent records of 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. They described an undocumented mistake which led them to separate a medicine used to treat depression (escitalopram) and a medicine used to treat acid reflux, heartburn and indigestion (esomeprazole) from one another on the shelving in the dispensary. But this was the same example as they used at the last inspection. People have shared their experiences of using the pharmacy and its services on the internet. The superintendent pharmacist provided assurance that action had been taken at the pharmacy to address the standards identified as not being met at the last inspection. But little had been done to make the necessary improvements despite feedback from the GPhC.

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 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 always clearly described within the SOPs. The pharmacy kept a record to show which pharmacist was the RP and when. But the superintendent pharmacist had already completed the record to show they were the RP for the next two days. The superintendent pharmacist explained that the pharmacy didn't supply prescription-only

medicines to people in an emergency. The private prescription register and most of the controlled drug (CD) registers weren't available at the pharmacy. The superintendent pharmacist had removed them from the pharmacy as they hadn't made entries in them for some time. But two current CD register sections were found during the inspection; one hadn't been used for over three years and the transactions for that week hadn't been recorded in the other. And the running balances recorded in these didn't match what was found at the pharmacy, and the address from whom a CD was received from wasn't recorded too. 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 old 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 pharmacy had safeguarding procedures. And the superintendent pharmacist knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person.

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

Summary findings

The pharmacy doesn’t have enough team members to deliver its services safely and effectively. And its team struggles to do all the things it needs to do and is behind with its work. Members of the pharmacy team can make decisions about what is right for the people they care for. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy had struggled to recruit and retain team members as well as cover any absences. But it received help from a volunteer from time to time. The superintendent pharmacist found it difficult to do all the things they needed to do as they were busy and didn’t always have the time to do them. So, they regularly stayed behind after work to try to keep on top of the workload. But they were still behind. And, for example, the pharmacy records weren’t kept up to date, some SOPs haven’t been reviewed for many years and the pharmacy was untidy and disorganised. People had to wait 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 superintendent pharmacist was a director of the pharmacy as well as its regular RP. They were responsible for managing the pharmacy. And 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. The superintendent pharmacist felt able to make decisions that kept people safe. And, for example, the pharmacy tried to keep certain medicines in stock that people couldn’t get from other pharmacies. The superintendent pharmacist was required to keep their professional skills and knowledge up to date as part of their annual revalidation process. They knew who they should raise a concern with if they had one. And a plastic screen was put on the counter following their feedback to try to help reduce the spread of airborne infections such as 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 had air-conditioning. It was 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, 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 procedures all the time. The pharmacy doesn't keep adequate records to show its working practices are safe and effective. And it can't show it has supplied the right medicine to the right person or show who was responsible for each service it provides. 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 superintendent 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 their time when talking to people about medicines. But queues of people developed quickly as the superintendent 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 medicines 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 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 superintendent pharmacist generally dispensed prescriptions or outstanding medicines 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 usually provided a brief description of each medicine contained within the multi-compartment compliance packs. And it sometimes supplied patient information leaflets. The superintendent pharmacist was aware of the rules on dispensing valproate-containing medicines in the manufacturer's original full pack. They understood that women or girls who were able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. And they knew that women or girls who were prescribed a 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 some medicines weren't. Members of the pharmacy team checked the expiry dates of medicines as they dispensed them or when they got a chance to. But they didn't record when they had done so as required by the pharmacy's SOPs. And some expired medicines, including out-of-date CDs, were found amongst in-date stock during the inspection. The pharmacy routinely rinsed out large plastic stock CD 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 enough 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 a process for dealing with the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). But no records of any recent MHRA recalls or the actions taken by the pharmacy in response to these were seen during the inspection.

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

Summary findings

The pharmacy generally has the equipment and the facilities it needs to provide its services safely. But the refrigerator it uses to keep medicines in that require refrigeration is too small and isn't fit for purpose or appropriately maintained.

Inspector's evidence

The pharmacy had some glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. The pharmacy team had access to 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 full up with stock, its door didn't seal properly when closed and the ice box required defrosting. The superintendent pharmacist explained that a refrigerator in the upstairs flat was sometimes used to store stock that couldn't be accommodated in the pharmacy refrigerator. But the superintendent pharmacist wouldn't allow access to the flat. And couldn't show that this refrigerator was appropriately maintained or safe to use and fit for purpose. The pharmacy kept records for the maximum and minimum temperatures of the pharmacy refrigerator. But none were available for the refrigerator in the flat. And the pharmacy team hadn't been recording the right values for the maximum and minimum temperatures for the pharmacy refrigerator. And the thermometers indicated that the maximum and minimum temperatures of the pharmacy refrigerator were outside of the appropriate range. The pharmacy positioned its computer screen so it could only be seen by a member of the pharmacy team. It restricted access to its computer and patient medication record system. And only an authorised team member could use them when they put in their password.

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.