General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: FastHeal Pharmacy and Clinic, 3 Mercia Walk, Woking, Surrey, GU21 6XS

Pharmacy reference: 9012367

Type of pharmacy: Internet / distance selling

Date of inspection: 10/09/2024

Pharmacy context

This NHS distance-selling pharmacy is set in a pedestrian area of Woking town centre. The pharmacy opens six days a week. It provides most of its NHS services at a distance. But people can visit its premises in person if they want to buy a medicine over the counter or to have their blood pressure checked or get a flu jab or a travel vaccination. The pharmacy dispenses people's prescriptions. It delivers medicines to people in person. It supplies multi-compartment compliance packs (compliance packs) to people who need help managing their medicines. And it delivers the NHS Pharmacy First service to help people who have a minor illness or need an urgent supply of a medicine.

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 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 not all met	4.3	Standard not met	The pharmacy doesn't suitably store all its medicines that it needs to keep in a refrigerator.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy manages its risks appropriately. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work at the pharmacy talk about the mistakes they make to try to stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy relocated to larger premises a few months ago. And it had more space to deliver its services from than it did before. People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had a notice that told people who the responsible pharmacist (RP) was at that time. It had standard operating procedures (SOPs) for the services it provided. And the superintendent (SI) pharmacist was in the process of reviewing these at the time of the inspection. But only a few SOPs had been signed by members of the pharmacy team to say they had read them and agreed to follow them. A team member explained they would refer repeated requests for the same or similar over-the-counter products, such as medicines liable to abuse, misuse or overuse, to the RP. And prescriptions couldn't be delivered and medicines weren't sold or supplied if a pharmacist wasn't present.

The team members who were responsible for making up people's prescriptions tried to keep the dispensing workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by an appropriately trained team member. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). The pharmacy team discussed the mistakes it made to learn from them and help stop the same sort of things happening again. But it could do more to make sure it routinely recorded and reviewed its mistakes to help improve the quality and the safety of its dispensing service.

The pharmacy had a complaints process. And its website told people how they could share their views and make suggestions about how the pharmacy could do things better. And there were a few online reviews about people's experiences of using the pharmacy and its services. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It kept an electronic log to show which pharmacist was the RP and when. But the log was sometimes inaccurate. And, for example, a pharmacist was recorded as being the RP for part of the inspection despite not being present. The pharmacy had a controlled drug (CD) register. But the pharmacy team didn't always complete the details of where a CD came from and the headings on each page in full. And corrections made to the register weren't always dated. The pharmacy recorded the supplies of the unlicensed medicinal products it made. But its team could do more to make sure it routinely recorded when it received and supplied one of these products and who it supplied the product to. The pharmacy team was required to record the emergency supplies it made and the private

prescriptions it supplied on its computer. But sometimes the details of the prescriber and the date of prescribing were incorrect in the private prescription records seen. The pharmacy team was reminded that an appropriate record needed to be made when a prescription-only medicine (POM) was supplied to a person in an emergency including the reason for making a supply even for requests referred to it through the NHS Pharmacy First service. And, in addition to standard labelling requirements, the words 'Emergency Supply' needed to be added to the dispensing label too. The SI gave an assurance the pharmacy team would review and strengthen its process for making emergency supplies and the pharmacy records would be maintained as they should be.

The company that owned the pharmacy was registered with the Information Commissioner's Office. People using the pharmacy couldn't see other people's personal information. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. And its website told people how their personal information was gathered, used and shared by the pharmacy and its team. But people's details weren't always crossed out or removed from the unwanted medicines returned to it before being disposed of. The pharmacy team had access to safeguarding guidance and other resources through the NHS Safeguarding mobile phone application. And pharmacists were asked to complete an appropriate safeguarding training course. Members of the pharmacy team 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 met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. Members of the pharmacy team can make decisions to keep the people they care for safe. They are comfortable about giving feedback to help the pharmacy do things better. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy team consisted of the RP, an accuracy checking dispensing assistant, two trainee dispensing assistants, a student pharmacist, three delivery drivers and a team member who was completing a trial period of work. The pharmacy had some vacancies. So, it depended upon its team, locum pharmacists and colleagues from another branch to cover absences. The people working at the pharmacy during the inspection included the SI, the RP, the accuracy checking dispensing assistant, a dispensing assistant from another branch, a trainee dispensing assistant, the student pharmacist and the team member who was completing a trial period of work. The RP was the pharmacy's regular pharmacist. They were responsible for managing the pharmacy and leading its team. And they supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist.

The SI gave assurance that members of the pharmacy team, including the pharmacy's delivery drivers, were required to do accredited training relevant to their roles after completing a probationary period if they hadn't done so already. People who worked at the pharmacy could ask questions and discuss their development needs with their manager when the pharmacy wasn't busy. They were encouraged to learn from their mistakes too. The pharmacy didn't set any targets or incentives for its team. And its team members felt able to make decisions that kept the people they cared for safe. Members of the pharmacy team knew who they should raise a concern with if they had one. And they were comfortable about making suggestions on how to improve the pharmacy and its services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy had a website. And this provided the information it needed to. The pharmacy didn't sell or supply medicines through its website. And it didn't offer a prescribing service. The pharmacy premises were air-conditioned, bright, clean, modern and secure. And the public-facing area was professionally presented. The pharmacy had five consulting rooms, a counter, a dispensary, a kitchenette, a retail area, a stockroom and toilets. But its dispensary had limited storage space available for the current workload. So, its worksurfaces could become cluttered when it was busy. And some items were stored in baskets or boxes on the floor.

The consulting rooms were available for services that needed one or if someone needed to speak to a team member in private. They were locked when they weren't being used to make sure their contents were kept secure. And people's conversations in them couldn't be overheard outside of them. The pharmacy had the sinks it needed for the services its team delivered. It had a supply of hot and cold water. And its team was responsible for keeping its premises clean and tidy.

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

Summary findings

The pharmacy doesn't suitably store all its medicines that it needs to keep in a refrigerator. But it largely sources and manages its other medicines appropriately. And its team carry out some checks to make sure these medicines are safe and fit for purpose. Members of the pharmacy team are friendly and helpful. And they usually dispose of people's unwanted medicines properly. The pharmacy provides services that people can access. Its working practices are generally safe and effective. And it keeps adequate records for its vaccination service to show that it has given the right vaccine to the right person. But it doesn't always give people the information they need with their compliance packs to take their medicines safely.

Inspector's evidence

People weren't allowed to visit the pharmacy in person to access its NHS services except when they needed a blood pressure check, a coronavirus booster or a flu jab. But they could telephone or email the pharmacy team when they needed to access its NHS services. The pharmacy didn't have an automated door. But its entrance was level with the outside pavement. And its team helped people who had difficulty in opening the door enter the premises and access the services the pharmacy was allowed to provide in person. Members of the pharmacy team were friendly and helpful. And they took the time to listen to people. So, they could help and advise them, and signpost them to another provider if a service wasn't available. The pharmacy had a small seating area for people to use when they needed to wait. It had a notice that told people when it was open. And its digital displays told people about its other services. But its website told people that it offered some services that it did not provide such as colonoscopies and mammograms. The SI gave assurance that the website would be reviewed to make sure only services offered would be advertised. People benefited from the NHS Pharmacy First service as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on GP surgeries to deal with people's urgent requests for medicines or treatments for some minor illnesses. The pharmacy had the patient group directions and protocols it needed for the NHS Pharmacy First service. It needed to provide the service remotely. And patients were usually seen by a pharmacist via an encrypted video link. But it was unclear if this was always the case. So, the SI gave an undertaking that the service would be reviewed and strengthened to make sure only remote consultations for eligible conditions were provided.

The pharmacy could use a tracked postal service to deliver medicines to patients who weren't local to the pharmacy. But it needed to risk assess and decide on how it would send medicines that required secure storage or refrigeration. The handover of medicines to the delivery person or postal worker took place at the pharmacy under the supervision of a pharmacist. The local delivery service was provided by employees. And the pharmacy kept a log to show it had delivered the right medicine to the right person. The pharmacy offered winter flu jabs, coronavirus boosters, childhood immunisations and travel vaccinations. It had the anaphylaxis resources and the patient group directions it needed for its vaccination service. And the pharmacists delivering the vaccination service were appropriately trained. But the RP didn't routinely ask a suitably trained team member to check they had selected the right vaccine before they administered it. The pharmacy kept a record for each vaccination it made to show it had given the right vaccine to the right person. And the records included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy

kept an audit trail of the person who had assembled and checked each prescription. But a patient information leaflet, a brief description and cautionary and advisory warnings of each medicine contained within the compliance packs weren't provided every time. So, people didn't always have the information they needed to take their medicines safely. The pharmacy made a supply of a medicine against a private prescription which wasn't written on the correct form. And its team recently made an emergency supply of a medicine it wasn't allowed to supply. But the SI had already addressed these matters with the pharmacy team.

Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. They were aware of the rules on dispensing valproate-containing medicines in the manufacturer's original full pack. And they knew where they could access the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. But it didn't always keep its medicines within their original manufacturer's packaging. And this meant the pharmacy team may not have all the information it needed if a particular make of medicine was recalled. Members of the pharmacy team checked the expiry dates of medicines when they dispensed them. But they haven't checked the expiry dates of medicines for some time and they didn't record when they last did a date check. They didn't routinely mark containers of liquid medicines with the date they opened them. And, apart from some CDs, they didn't always mark products which were soon to expire. These things meant there was an increased risk of someone being given an out-of-date medicine by mistake. The pharmacy team removed some POMs and pharmacy medicines during the inspection that had been mistakenly put out on open display in the retail area. The pharmacy stored CDs, which weren't exempt from safe custody requirements, securely. But its team couldn't demonstrate that medicines, which needed to be refrigerated, were kept at an appropriate temperature. The temperature ranges of the refrigerators were below 2 degrees Celsius and above 8 degrees Celsius. And, at the time of the inspection, the pharmacy team could only show that the temperature range of one of the refrigerators had been recorded on four occasions over the past six weeks. The pharmacy had procedures for handling people's unwanted medicines. And these were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But some patient-returned medicines that needed to be disposed of in a certain way and a cytostatic medicine was found in a waste bin not intended for hazardous medicines. 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 its team could do more to make sure it recorded the actions it took when it received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And its team 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 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 a community pharmacy representative group to ask for information and guidance. The pharmacy had the medical refrigerators it needed to store pharmaceutical stock requiring refrigeration. It had suitable equipment for the services it provided including measuring a person's blood pressure. And this equipment appeared to be well maintained. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. But its team members could do more to make sure their NHS smartcards were stored securely when they weren't working.

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.