

Registered pharmacy inspection report

Pharmacy Name: Wise Pharmacy, 3-5 Granville Street (Unit 5-6),
Runcorn, Cheshire, WA7 1NE

Pharmacy reference: 9012461

Type of pharmacy: Closed

Date of inspection: 09/12/2024

Pharmacy context

This is a distance-selling pharmacy operating from a commercial premises located in a retail park, mainly serving the local population. It mainly prepares NHS prescription medicines, and it orders people's repeat prescriptions on their behalf. Most people receive their medicines in multi-compartment compliance packs to help make sure they take them safely and there is a home delivery service. The pharmacy also supplies medicines to residents of a nursing home.

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	1.6	Standard not met	The pharmacy's Responsible Pharmacist records and controlled drugs registers are often illegible.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not enrol new team members on to an appropriate training course for the role they are undertaking. So, the pharmacy cannot provide assurance that they are acquiring the skills and knowledge they need for their role.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy does not provide appropriate information to people to help them identify each medication in their compliance pack. And it usually does not supply the product information leaflet for each medicine to people using compliance packs.
		4.3	Standard not met	The pharmacy does not monitor temperatures for one of its medication refrigerators. So it may not be able to demonstrate that it stores cold chain 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 largely keeps the records in line with requirements, but its responsible pharmacist and controlled drugs (CD) records are often illegible. So it is not always possible to identify who is responsible for the services it provides, or the details regarding the CDs it obtains or supplies as required by law. The pharmacy team has written instructions to help make sure it provides safe services. But it cannot always demonstrate how team members review mistakes that occur, so they may miss some learning opportunities. Pharmacy team members have a basic understanding of their role in securing people's confidential information, and they demonstrate how to support vulnerable people.

Inspector's evidence

The pharmacy had written procedures that covered safe dispensing, including in compliance packs, the responsible pharmacist (RP) regulations and controlled drugs (CDs). Not all pharmacy team members had read all these procedures, including the trainee dispensers. The RP explained that he had coached and closely supervised trainees to make sure they prepared prescription medication safely. Team members were observed referencing the prescription when preparing medicines.

The dispensers did not always initial dispensing labels on compliance packs, which could make it difficult to clarify who prepared each prescription medication and limit their opportunities to learn and improve. The pharmacy team recorded the mistakes it identified when dispensing medicines. But many records were illegible and the reasons for these mistakes was not always clear. The RP, who was the regular pharmacist, periodically reviewed these records, but they did not discuss them with the team. So, the pharmacy might miss additional opportunities to learn and mitigate risks in the dispensing process.

The pharmacy had written complaint handling procedures, so staff members knew how to respond to any concerns. The pharmacy had not publicised information explaining how people could make a complaint. So, they may feel less inclined to raise a concern.

The pharmacy had professional indemnity insurance for the services it provided. The RP displayed their RP notice. Many of the RP's entries in the RP log and several randomly selected CD registers were illegible, which made it difficult to rely on these records in the event of a query and may be in breach of the relevant legislation. The pharmacy had a record of CDs that people had returned for disposal. The RP confirmed that he documented each CD running balance check that he completed. These records indicated that the pharmacy infrequently checked the running balances. A randomly selected running balance had a stock discrepancy.

New team members verified that they had signed a patient confidentiality agreement and understood the basics of keeping people's information private. However, they had not completed any formal data protection training. The pharmacy generally secured confidential papers, but some practices may unintentionally lead to a data breach, which the RP and head office agreed to address. Team members used passwords to access NHS electronic patient data and some of them had their own NHS security card to access this information. But new team members had not applied for a card, so it was not always possible for each of them to individually access the system. There was no publicly available information about the pharmacy's privacy policy. So, people may have more difficulty finding out how the pharmacy

protects their data. Head office staff removed paper-based confidential waste, but it was unclear how this waste was subsequently securely transported and disposed.

Team members and the RP had completed level one and three safeguarding training respectively. The pharmacy liaised with GP practices when it was concerned that compliance pack people were struggling to manage their medication. This included re-assessing the most suitable supply interval to avoid them becoming confused. But the pharmacy did not keep corresponding records of these assessments to support the person's ongoing care.

The pharmacy kept records of the care arrangements for people using compliance packs, including their next of kin's or carer's details and any specific medication delivery arrangements. This meant the team members had easy access to this information if they needed it urgently.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy has enough staff most of the time. Some team members periodically work additional shifts to make sure people consistently receive a prompt service. However, the pharmacy does not always enrol new team members onto an essential training course. And there is no structured plan to monitor and support trainee team member's progress. So, the pharmacy cannot provide assurance that they are acquiring the skills and knowledge they need for their role.

Inspector's evidence

The pharmacy team consisted of the RP, a senior dispenser who was the manager, and two trainee dispensers. The pharmacy had enough staff to manage its workload most of the time. However, there were periods when the team experienced increase service demand that suggested the staffing arrangements needed to be reviewed. The RP had not previously informed the superintendent's office that they were working some additional hours outside of the pharmacy's operating hours during one or two weeks each month when the nursing home's medication and significantly more compliance packs were due. And the team sometimes started preparing compliance packs before the pharmacy received the prescription. To address this, the pharmacy had recently limited its compliance pack service capacity to help make sure it continued to supply existing patients promptly. Head office confirmed that the senior dispenser shall be enrolled on an accuracy checker course and, in the interim, additional staff shall be provided to help make sure all medication preparation is completed on time in the pharmacy.

The pharmacy received most of its prescriptions via the prescription management and NHS Electronic Prescription Service. The public did not visit the pharmacy and team members communicated effectively with each other to manage the service demand. These arrangements help to minimise sustained periods of increased workload pressure, and make sure people consistently received their medication on time. The team did not have any official targets or incentives for the scale of services it provided.

One of the trainee dispensers started working at the pharmacy around one month ago. The other trainee dispenser, who started working at the pharmacy around five months ago, had not been enrolled on an accredited dispenser qualification training course. The RP explained that they had informed head office around two weeks ago that the trainee needed enrolling. However, head office had not responded.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are generally clean and tidy, and it provides a suitable environment for delivering the pharmacy's services.

Inspector's evidence

The pharmacy was clean and tidy. The open-plan design provided enough space for the volume and nature of the pharmacy's service. The premises was large enough such that each team member had their own workstation, so there was sufficient space to safely prepare prescription medication, including compliance packs. The pharmacy did not require a consultation room because people did not visit the premises. The level of cleanliness was appropriate for the services provided. The team could secure the pharmacy to prevent unauthorised access.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy has some dispensing practices that are generally safe. It gets its medicines from licensed suppliers. But the pharmacy does not manage medicine stock effectively to make sure it is in good condition and suitable to supply. And it does not always keep records of deliveries so it can confirm people receive their medicines.

Inspector's evidence

The pharmacy operated Monday to Friday 9am to 6pm. The public could contact the pharmacy via telephone and email and all medications were delivered.

The pharmacy had written procedures that covered the safe dispensing of higher risk medicines such as methotrexate lithium and anti-coagulants. The pharmacy did not have a written procedure for dispensing some other medicines which were considered higher risk, such as fentanyl patches and valproate.

The pharmacy reviewed valproate prescriptions to identify anyone who was in the at-risk group. The RP was not fully aware of the requirement to supply valproate in the original packaging, that two specialists had to agree to initiate new patients in the at-risk group on valproate, or confirm these people had their annual review. The updated MHRA guidance was discussed with the RP.

The team had a scheduling system to make sure people received their compliance packs on time. It kept a record of people's current compliance pack medication that also stated the time of day they were to take them. This helped it effectively query differences between the record and prescriptions issued by the GP surgery, and it reduced the risk of it overlooking medication changes. The team checked for its emails twice daily for any hospital discharges and communications from patients for medication changes. The pharmacy also kept records of verbal communications about medication queries or any changes for people using compliance packs. But these records did not always include the full details such as the method of communication or who conveyed the change.

To help manage the workload team sometimes started to prepare compliance pack medicines before it received the prescription. This usually occurred during one or two weeks each month when the nursing home's medication and significantly more compliance packs were due. On these occasions it referred to the patient's records instead, which may lead to mistakes. The pharmacy did not provide people a description of each medicine inside their compliance packs, and it only provided a patient information leaflet when people requested it. This may lead to difficulties if patients or carers need to identify them.

The team prompted people to confirm the repeat prescription medications they required, which helped the pharmacy limit medication wastage, and people received their medication on time. The pharmacy retained records of the requested prescriptions. This meant the team could effectively resolve queries if needed.

The team applied a dispensing label to the inner container of nursing home resident's external applications and each injectable device, so that nursing home staff could safely identify each person's medication and the usage instructions. The pharmacy issued medication administration record (MAR) sheets to help support the nursing home staff in administering medication to their residents. But the

pharmacy did not have bespoke MAR sheets designed to support administering high risk medications or injections or body maps for external applications. So, nursing home staff may not always know how to safely and appropriately administer these products in a way that is specific to individual residents.

The team promptly notified the nursing of any missing prescriptions and unavailable medication, so that there was sufficient time to address these issues. The pharmacy usually supplied resident's monthly repeat medicines to the nursing home one week before they were needed.

The team used colour-coded baskets during the dispensing process to separate people's medicines and organise its workload according to compliance pack, nursing home and original pack dispensing. Part-prepared compliance packs were temporarily stored on separate shelving, which help to easily assess which people's medications needed prioritising.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and generally stored them in an organised manner, including refrigerated and CD products. Staff members did not always permanently mark part-used medication stock cartons, which might lead to selecting the incorrect quantity when dispensing and supplying medication. The team suitably secured its CDs, quarantined its obsolete CDs and it used destruction kits for denaturing unwanted CDs.

The pharmacy had two refrigerators for storing medication. Records indicated that in the last six months one of the refrigerator's temperatures were checked around twice each week on most weeks, but not at all during some weeks. Team members recalled that they usually checked the temperature every few days, but they may not have always recorded them. The second refrigerator was functioning and internally was significantly cooler than the ambient temperature. But it did not have a functioning thermometer for the last three months, so its operating temperatures had not been verified during this period, and the team had not arranged a replacement. So, it was unclear if some medicines had been stored appropriately. Head office confirmed that it shall address this.

The team recently checked the expiry dates of all the stock and disposed of a large quantity of expired medicines because the pharmacy had not completed any expiry date checking for a prolonged period. Several randomly selected stock medicines that were checked during the inspection had reasonably long shelf lives, except for one product which expired in November 2024 and was disposed of when identified.

The pharmacy kept a daily schedule of medicines delivered to people, but these were not filed in any coherent order, which may make it difficult to retrieve a record if needed. The delivery driver did not always record on the schedule when they handed over medication to people, which may lead to difficulties in the event of a query. The pharmacy kept additional records for delivered CDs that included the recipient's signature, patient's name and address, and the delivery date. But these records did not include supplying pharmacist's or driver's details, and whether the driver asked the recipient for proof of their identity or if they showed it. The pharmacy did have a written procedure that clarified how medicines, including CDs, should be delivered safely and securely.

The team took appropriate action when it received alerts for medicines suspected of not being fit for purpose, and it kept corresponding records that confirmed this. It disposed of obsolete medicines in waste bins kept away from its medicines stock, which reduced the risk of these becoming mixed with stock or supplying medicines that might be unsuitable.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy team has the facilities that it needs for the services it provides. The equipment is appropriately maintained and used in a way that protects people's privacy.

Inspector's evidence

The team kept the dispensary sink clean; it had hot and cold running water and an antibacterial hand sanitiser. The team had a range of clean measures. So, it had facilities to make sure it did not contaminate the medicines it handled and could accurately measure and supply people their prescribed volume of medicine. The team members had access to the British National Formulary (BNF) online.

The team had facilities that protected peoples' confidentiality. Computer systems were password protected and the pharmacy regularly backed up people's data on its PMR system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. And it had facilities to store people's medicines and their prescriptions securely.

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.