

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, Unit 11, Fife Central Retail Park, KIRKCALDY,  
Fife, KY2 6QL

**Pharmacy reference:** 1084069

**Type of pharmacy:** Community

**Date of inspection:** 12/08/2024

## Pharmacy context

The pharmacy is in a retail park on the outskirts of Kirkcaldy, Fife. It opens extended hours seven days a week, and its main business is dispensing NHS prescriptions and supplying a range of over-the-counter medicines. The pharmacy provides the NHS Pharmacy First service and its team members advise on minor ailments and medicines use.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

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 met	N/A	N/A	N/A
<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 met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy has written procedures in place to help ensure that its team members work safely. The pharmacy's team members review and learn from any mistakes they make to improve the safety of the services they offer. The pharmacy generally keeps people's private information safe. And it keeps all the records required by law. The pharmacy asks people for their feedback on its services and responds appropriately. And its team members know how to help protect the safety of vulnerable people.

### Inspector's evidence

The pharmacy had a set of electronic standard operating procedures (SOPs), and it could show that team members had read and agreed to follow them. The SOPs covered tasks such as dispensing medicines, information governance and reporting dispensing incidents. The manager demonstrated how they had oversight of each individual team member's progress with signing off the SOPs. There was a quiz for each SOP, which had to be successfully completed before the individual team member was signed off to carry out the associated tasks. Team member's roles and responsibilities were linked to the SOPs, so that they only carried out tasks they were competent to do. Team members described their roles within the pharmacy and the processes they were involved in. They accurately explained which activities could not be undertaken in the absence of the responsible pharmacist. The pharmacy employed an Accuracy Checking Pharmacy Technician (ACPT). Team members described the process for prescriptions being clinically checked by the pharmacist prior to dispensing and how this was clearly marked on the prescriptions. This enabled the ACPT to complete the accuracy check. The pharmacy had a business continuity plan to address disruption to services or unexpected closure. Team members described the process for closing the pharmacy when there was no responsible pharmacist available.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as near misses. And they recorded errors that had been identified after people received their medicines. Team members were responsible for recording their own errors which gave the opportunity for them to consider contributing factors. The ACPT explained their role as patient safety champion. They provided individual feedback to team members throughout the month on their mistakes, and then reviewed all near misses and errors at the end of each month. They created a patient safety review summary which was displayed in the dispensary and provided a focal point for a monthly patient safety meeting. This allowed team members to learn from common trends and they introduced strategies to minimise the chances of the same error happening again. For example, the pharmacy used bar-code scanning technology which helped to manage the risk of selection errors. And pharmacy team members now marked prescriptions with "NB" to highlight medicines that did not have a recognised barcode. This prompted team members and accuracy checkers to perform an extra check when dispensing these medicines.

The pharmacy asked people for feedback on the pharmacy's services using prompt cards with a quick response (QR) code. There was a complaints procedure in place, and this was detailed in a patient guide leaflet in the leaflet display. The pharmacy encouraged people to sign up for text message notification when their prescription was ready following feedback from people attending the pharmacy before their prescription was complete.

The pharmacy had current professional indemnity insurance. It displayed the correct responsible

pharmacist notice and had an accurate responsible pharmacist record. From the records seen, it had accurate private prescription records and complete records for unlicensed medicines. The pharmacy kept controlled drug (CD) records with running balances. A random check of the physical stock of three controlled drugs matched the balance recorded in the register. Stock balances were observed to be checked against the balances in the CD register on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy.

Pharmacy team members were aware of the need to protect people's private information. They completed yearly training on information governance and general data protection regulations. And they separated confidential waste for secure destruction. They mostly kept people's confidential information in the dispensary, visible only to pharmacy staff. A privacy notice in the retail area provided assurance that the pharmacy protected people's personal information. The pharmacy had a documented procedure about the safeguarding of vulnerable adults and children. This included access to local contact details and processes. And a notice displayed on the dispensary wall helped team members understand how to raise any concerns they may have. A team member explained the process they would follow if they had concerns and would raise concerns to the RP. They were aware of the Ask for ANI (action needed immediately) scheme to help people suffering domestic abuse access a safe place.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy's team members have the necessary qualifications and skills to safely provide the pharmacy's services. They manage their workload in an organised and safe manner. They feel comfortable raising concerns, giving feedback and suggesting improvements to provide a more effective service.

### Inspector's evidence

The pharmacy employed two regular pharmacists to cover the pharmacy's extended opening hours. A company-employed relief pharmacist worked one day each week to provide extra cover and allowed the team to plan for the provision of services. The pharmacy team included a part-time ACPT, two full-time pharmacy assistants, two part-time pharmacy assistants, two trainee pharmacy assistants, and a university student who worked ad-hoc and was enrolled in training. The store manager was also trained as a pharmacy assistant and provided cover when required. Typically, there were four team members working with a pharmacist at most times.

The pharmacy planned learning time during the working day for all team members to undertake regular training and development. It provided team members undertaking accredited courses with further additional time to complete coursework. A trainee dispenser was observed being supervised in their role and had a training plan that they were working through. The ACPT had received recent training to provide the NHS take-home naloxone service. And the pharmacist had attended a recent training session on skincare which they felt had improved their knowledge in this area. Team members had informal annual development meetings with the pharmacy manager to identify their learning needs.

Team members were observed to work on their own initiative. They asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. They felt able to make suggestions and raise concerns to the manager or area manager. The company's professional standards team shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. The pharmacy team discussed incidents and how to reduce risks. The pharmacy had a whistleblowing policy that team members were aware of. Team members were set some performance targets related to the services the pharmacy provided. They found them manageable, and they did not let targets affect their professional judgement.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises are appropriate for the services it provides. They are clean, secure, and well maintained. And the pharmacy has a suitable, sound-proofed room where people can have private conversations with the pharmacy's team members.

### Inspector's evidence

The pharmacy was within a large retail store which held a large variety of toiletries, cosmetics, and other miscellaneous items. The pharmacy premises comprised of a healthcare counter and dispensary within the retail store and a separate back shop area included storage space and staff facilities. The premises were clean, hygienic and well maintained. A sink in the dispensary had hot and cold running water, soap, and clean hand towels. Team members had daily and weekly routines to keep the worksurfaces and shelving clean. There was ample space to store the pharmacy's medicines and the dispensary floor was kept clear of obstruction. The pharmacy's overall appearance was professional. The pharmacy had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions.

People in the retail area were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room which was clean and tidy with a desk, chairs, sink and password-protected computer. And the door closed which provided privacy for confidential conversations and the provision of services. The door was kept locked when the room was not in use to prevent unauthorised access. The pharmacy also had a separate enclosed area for specialist services such as substance misuse supervision. Temperature and lighting were comfortable throughout the premises.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy makes its services accessible to people. And it delivers its services safely and effectively. The pharmacy sources its medicines from recognised suppliers, and it completes regular checks of them to make sure they are in date and suitable to supply. The pharmacy team provides appropriate advice to people about their medicines.

### Inspector's evidence

The pharmacy provided extended opening hours, weekday evenings and Sunday. Its opening times were clearly advertised on the external wall. And the services offered were advertised on the pharmacy's main window and on a display close to the dispensary. The pharmacy was accessed via a level entrance and automatic door from the car park. And there were priority parking spaces allocated for disabled and people with young children. All team members wore badges showing their name and role. The NHS Pharmacy First service was very popular, particularly due to the pharmacy's extended opening hours. Team members were trained to deliver advice and treatment within their competence and under the pharmacist's supervision. They referred to the pharmacist as required. The pharmacy had patient group directions (PGDs) which included for unscheduled care, treatment of urinary tract infections, treatment for skin infections, emergency hormonal contraception, and chlamydia treatment. People were often signposted to the pharmacy by the NHS out-of-hours teams for a Pharmacy First consultation with a pharmacist. The pharmacist received details of the individual referrals and any supporting information via secure NHS email before people arrived in the pharmacy. This allowed them to prepare and ensure the referral was appropriate. And they regularly checked for new messages throughout the day. Pharmacists made records of the advice they gave to people, and when they referred people onto another service. For example, the person's GP or the out-of-hours treatment centre.

Pharmacy team members followed a logical and methodical workflow for dispensing. They initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. Team members also initialled prescriptions to provide an audit trail of personnel involved at every stage of the dispensing process including labelling and handing out. Each medicine's barcode was scanned using a device linked to the pharmacy's patient medication record (PMR) to ensure the correct product had been selected. There was an extra process to follow if there was either no barcode or if the barcode wasn't recognised. Team members used baskets to separate people's medicines and prescriptions. And they used electronic prompts on devices and coloured labels attached to prescriptions to act as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a CD that needed handing out at the same time. Or to provide appropriate advice and counselling to people receiving higher-risk medicines including methotrexate, lithium and warfarin. Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. And they always dispensed valproate in the original pack.

Some people received medicines from NHS Medicines, Care and Review (MCR) serial prescriptions. The pharmacy dispensed these weekly in advance of people collecting them. Team members checked if people needed each prescribed item when they came to collect, in order to avoid waste. And they

maintained records of when people collected their medication. The pharmacy sent many of its prescriptions for assembly at the company's offsite hub pharmacy. There was a procedure for identifying which prescriptions to send, and which to assemble in the pharmacy. The pharmacist completed the clinical check and accuracy check of the prescription data prior to submitting to the hub pharmacy. Assembled prescriptions were returned to the pharmacy two days later. They were then matched with the original prescriptions and any other items that had been assembled onsite. Team members scanned a barcode on the prescription bag label when handing out completed prescriptions using the PMR. Any prompts the pharmacist may have applied, such as for providing additional counselling, had to be followed and confirmed onscreen before the bag could be handed over.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves and in drawers. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. And team members followed the sale of medicines protocol when selling these. The pharmacy stored items requiring cold storage in two fridges and team members monitored and recorded minimum and maximum temperatures daily. They were aware of the appropriate action to take if these went above or below accepted limits. Team members regularly checked expiry dates of medicines and a sample of those inspected were found to be in date. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy kept CDs securely in cabinets. Medicines inside the cabinets were kept in an orderly manner with designated space for holding assembled medicines, date-expired and patient-returned CDs. The pharmacy had disposal bins for expired and patient-returned stock. It actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records about what it had done.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

### Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had access to the internet for up-to-date information on services and for clinical information.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. Team members kept clean crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. The pharmacy used a manual pump for measuring doses of substance misuse medicines weekly. Team members cleaned it at the end of each use and poured test volumes to confirm accuracy. The pump was calibrated annually by an external company. The pharmacy team kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in a locked filing cabinet in the dispensary inaccessible to the public. It had cordless phones so that team members could talk in quieter areas. Computers were password protected and no confidential information was visible to people using the pharmacy.

### 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.