

Registered pharmacy inspection report

Pharmacy Name: Boots, 88 - 94 High Street, FORRES, Morayshire,
IV36 1NX

Pharmacy reference: 1099044

Type of pharmacy: Community

Date of inspection: 19/03/2024

Pharmacy context

This is a community pharmacy within the town of Forres in Moray. Its main activity is dispensing NHS prescriptions. And it supplies medicines in multi-compartment compliance packs for some people who need help remembering to take their medicines at the right times. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises 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
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 met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy has suitable systems to identify and manage the risks associated with its services. Team members record any mistakes they make and review them to identify the cause. And they make the necessary changes to stop mistakes from happening again. Team members suitably protect people's private information and they keep the records needed by law.

Inspector's evidence

The pharmacy had a set of electronic standard operating procedures (SOPs), and team members had read and agreed to follow them. The SOPs covered tasks such as dispensing medicines, information governance and reporting dispensing incidents. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the pharmacist. SOPs had been reviewed by all team members within the last year. 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 the completion of the check was clearly marked on the prescriptions. The pharmacy had a business continuity plan with clear procedures to follow to address disruption to services or unexpected closure. Team members described the process for closure of the pharmacy when there was no responsible pharmacist available. The pharmacy had a documented process for notifying key stakeholders if the pharmacy was forced to close including contact details for vulnerable people who were due to collect medication during the period of closure.

Team members kept records about dispensing mistakes that were identified before the person received their medicines, known as near misses. And they recorded errors that had been identified after people received their medicines. The team had a monthly safety meeting to review all near misses and errors so that they could learn from them. And they took action to help minimise the chances of the same errors happening again. They gave examples such as highlighting different strengths of medicines to prevent a selection error. Team members received individual feedback on their errors. The ACPT explained their role as 'patient safety champion.' They had created a patient safety board to co-ordinate all communications around patient safety. The pharmacy superintendent shared information about incidents from elsewhere in the organisation for all team members to learn from. This document was prominently displayed on the safety board in the staff room. Team members signed the document to confirm they had read it. The pharmacy had a complaints procedure and welcomed feedback.

The pharmacy had current professional indemnity insurance. It displayed the correct responsible pharmacist (RP) notice and had an accurate RP record. Private prescription records were in order, including records about emergency supplies and veterinary prescriptions. And the records for unlicensed medicines were complete. The pharmacy kept controlled drug (CD) records with running balances. A random balance check of two controlled drugs matched the balances recorded in the register. Stock balances were checked against the register on a weekly basis. The pharmacy had an up-to-date CD destruction register to record CDs that people had returned to the pharmacy. Electronic patient medication records (PMR) were regularly backed-up to avoid data being lost.

Pharmacy team members were aware of the need to protect people's private information. They demonstrated an understanding of data protection and had completed general data protection training.

They separated confidential waste for secure destruction offsite. No person-identifiable information was visible to the public. The pharmacy had a documented procedure and contact details to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children. A team member explained the process they would follow if they had concerns and would raise concerns to the RP. And they provided a recent example of contacting a person's GP after the delivery driver reported their concerns about their welfare. Team members were aware of the Ask for ANI (action needed immediately) scheme to help people suffering domestic abuse access a safe place. The pharmacist was registered with the protecting vulnerable group (PVG) scheme.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to manage its workload and they have the appropriate training for the jobs they do. They complete ongoing training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy employed one full-time pharmacist, a full-time pharmacy assistant who also held the role of store manager, a part-time ACPT, a full-time trainee pharmacy technician, three part-time pharmacy advisors and three part-time trainee pharmacy advisors. Team members were seen to be managing the workload. Part-time team members had some scope to work flexibly providing contingency for absence. All team members demonstrated a good rapport with people who visited the pharmacy. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

The pharmacy planned learning time for all team members to undertake regular training and development. Trainee team members were observed being supervised in their role and described the training plan that they were working through. A locum pharmacist worked alongside the RP on one day each week. This allowed the regular pharmacist time to complete extra tasks, which included supporting trainees. Team members asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when needed. They demonstrated a clear understanding of medicines liable to misuse and would speak to the pharmacist if they had any concerns about individual requests. They also recognised when the same people made repeated requests and would refer them to the pharmacist.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable 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 premises were average-sized and included a retail area, dispensary and back shop area, where there was storage space, an office, and staff facilities. The premises were clean, hygienic, and well maintained. There were sinks in the dispensary, staff room and toilets. These had hot and cold running water, soap, and clean hand towels. The pharmacy's overall appearance was professional. It had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed which provided privacy. The pharmacy also had a separate 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 provides a range of services which it makes accessible to people. And it manages its services well to help people look after their health. The pharmacy sources, stores and manages medicines safely. This ensures the medicines it supplies are fit for purpose. And the pharmacy team provides appropriate advice to people about their medicines.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and a power-assisted door. And the centre of the pharmacy counters were low in height for people with wheelchairs to use. The pharmacy advertised some of its services and its opening hours in the main window. It had a hearing loop in working order for people wearing hearing aids to use. And it could provide large print labels for people with impaired vision.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used tubs to separate people's medicines and prescriptions. And they attached coloured labels to people's dispensed medicines to use as an alert when they were handed out. For example, to highlight interactions between medicines or the presence of a fridge line or a CD that needed handing out at the same time. Team members added their initials to dispensing labels to provide an audit trail of who had dispensed and checked medicines. They also initialled prescriptions to provide an audit trail of team members involved at every stage of the dispensing process including labelling and handing out. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person, and one was kept with the original prescription for reference when dispensing and checking the remaining quantity. Many people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy prepared these in advance, usually seven days before they were needed. 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 supplied medicines in multi-compartment compliance packs to people that needed extra support with their medicines. The pharmacy managed the dispensing and the related record-keeping for these on a four-weekly cycle. It kept records of people's medicines and administration times for each person in folders for each week of assembly. And it kept records of changes to people's medication. The pharmacy retained written communication from the person's general practice. This included copies of discharge letters and notification of change forms which created a clear audit trail of any medication changes. Compliance packs were labelled clearly with directions and descriptions then stored in individual files pending supply.

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. The pharmacy supplied patient information leaflets and patient cards with every supply and had recently completed an audit of people taking valproate to highlight any people the pharmacy supplied valproate to who may be at risk if they became pregnant. The pharmacy team used laminated alert cards to highlight other higher-risk medicine prescriptions

that may require further intervention from the RP. The pharmacy had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, and emergency hormonal contraception (EHC). The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines in original packaging in drawers and on shelves. Items requiring cold storage were stored in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Team members regularly checked expiry dates of stock medicines. From a random sample looked at, all were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. Team members followed the sale of medicines protocol when selling these.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs for providing its services. Its team members use the equipment and facilities in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had internet access to provide access to a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines. The pharmacy had a range of crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. The pharmacy team kept clean tablet and capsule counters in the dispensary. And team members had access to personal protective equipment such as disposable gloves for handling medication.

The pharmacy stored paper records in locked filing cabinets in the dispensary and office inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented people's information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave them unattended unless they were locked. The pharmacy had cordless phones, so that team members could have conversations with people in private.

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.