General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: AYP Healthcare, 160-164 Lancaster Road North, Preston, Lancashire, PR1 2PZ

Pharmacy reference: 9011523

Type of pharmacy: Internet / distance selling

Date of inspection: 16/11/2021

Pharmacy context

This is an online pharmacy which people access using the website http://ayp.healthcare. It is situated within a warehouse near to Preston City Centre. The pharmacy's main service is online sales of 'over the counter' medicines. It also dispensed a low number of medicines for prescriptions issued by an online prescribing service. The pharmacy has another branch located in Romford which provides NHS services. The pharmacy website provides access to the services of both branches but does not make clear which is which.

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	1.1	Standard not met	The pharmacy is not able to show it has properly considered all of the risks associated with its services.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	People access pharmacy services via websites. But the websites do not make clear which pharmacy is actually providing the service. This may cause confusion and means people using the service may not be able to make informed choices.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy has some safeguards in place to help it supply medicines safely. But the safeguards are not always effective and pharmacy policy is not always applied to control sales as intended. The pharmacy asks questions before it sells a medicine so it can check whether it is suitable. But it sometimes supplies medicines more frequently than should be needed, or in larger quantities, without checking why they are needed.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

Members of the pharmacy team follow written procedures to help them work effectively. They keep the records that are needed by law, and they understand how to keep private information safe. But the pharmacy has not fully considered the risks associated with the services it provides. Which means that it does not have enough safeguards in place to make sure medicines are always supplied safely. Some records are kept when things go wrong, but near miss incidents are not recorded so some learning opportunities may be missed.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which had recently been issued. Members of the pharmacy team had signed to say they had read and accepted them. Roles and responsibilities of the pharmacy team were described in the SOPs. A trainee dispenser was able to explain what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The responsible pharmacist (RP) had their noticed displayed in the pharmacy. The website had a link to an RP notice, but it was for a pharmacist who had not worked at this branch as the RP. This was misleading and may cause confusion.

The pharmacy manager explained that she, the superintendent pharmacist (SI) and the owner, had discussed which medicines they would sell on the website and the maximum of each permitted per order. The owner said they had also discussed the risks with their pharmacy services, but there was no written risk assessment to show how they had identified or managed these risks. A spreadsheet had been produced that contained a list of medicines that could be sold and their respective quantity limits, but there was no further information about why these decisions had been made or whether other risks with selling specific medicines had been considered. The pharmacist said she would manually check if the order contained paracetamol and the quantity requested to ensure it was within a safe limit. But there were no further controls to identify or restrict medicines that could be misused when used in combination.

The pharmacy dispensed some prescriptions issued by an online prescribing service 'www.manbehindthemirror.co.uk.' This service used a GMC-registered UK based doctor to assess and prescribe medicines for the conditions of anxiety, erectile dysfunction and hair loss. The director said he and the SI had risk assessed the service but had not kept any record of this. So it was not clear what risks had been identified or how they were being managed.

Details about how to contact the pharmacy were available on its website. And there was information about how to return items back to the pharmacy. The pharmacy had a complaints procedure but there was no information on the website about it, so people may be unsure how they can raise concerns. Any complaints the pharmacy received were usually responded to by email to provide an audit trail. If a patient reported that they had received incorrect medicines, the incident was investigated, and details were recorded. The pharmacy manager said that in practice there were few errors made due to a barcode scanning system they used to confirm whether the product was correct. But that if they found an error had been made, they would normally give further training to the members of the team involved. Near miss incidents were not recorded and there was no formal review of the error records to identify any trends or underlying causes. The manager explained that action would be taken to manage any risks that were identified. And she gave an example that the stock of peppermint and aniseed

flavours of Peptac liquid had been separated to help prevent picking errors.

A current certificate of professional indemnity insurance was available. The records for the RP and private prescriptions appeared to be in order.

An information governance (IG) policy was available. Each member of the team had signed a confidentiality agreement, and these were stored in the SOP folder. When questioned, a trainee dispenser was able to describe what counted as confidential information and how it was segregated to be destroyed using the on-site shredder. A privacy notice was available on the pharmacy's website.

Safeguarding procedures were included in the SOPs. The pharmacy manager had completed level 2 safeguarding training and she was also aware about raising concerns where necessary. But she was unaware about how to raise a concern about a person who may not live locally. So there may be a delay in raising concerns about people's welfare.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload. Members of the pharmacy team are appropriately trained for the jobs they do.

Inspector's evidence

The pharmacy team included two pharmacists and two trainee dispensers who were on accredited training programmes. There were also 10-15 operational staff who were not pharmacy trained. The operational staff were responsible for stock control and packaging for despatch. The normal staffing level was a pharmacist, a trainee dispenser and 9 operational staff. The volume of work appeared to be managed adequately. Staffing levels were maintained by part-time staff and a staggered holiday system.

The pharmacist was allowed to exercise her professional judgement when assessing the suitability of P-medicine sales. A log of refused sales was kept, and it contained the initials of the pharmacist who was responsible for refusing the sale. The trainee dispenser said she received a good level of support from the pharmacy manager. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or SI. There were no professional targets in place.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy premises are suitable for the services provided. But the pharmacy website does not make clear that it is offering services provided by two different pharmacies, or which services are provided by which. This could cause confusion and may be misleading. The pharmacy is associated with an online prescribing serviced that is accessed via a separate website. The prescribing service website does not make clear who is issuing the prescriptions or which pharmacy will be supplying the medicines. This means people may not properly understand the service they will receive.

Inspector's evidence

The premises were an industrial unit closed to members of the public. It was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. Various heaters helped to control the temperature. Lighting was sufficient. The staff had access to a kitchenette and WC facilities.

The pharmacy had a website which was used to access its services. The website displayed the GPhC logo which linked to the register entry for this pharmacy. The website also allowed access to NHS services which were provided by the pharmacy's other branch which was located in Romford. This was explained via a link on the NHS services part of the website. But the website did not clearly explain that there were two different registered pharmacies involved, or which services were provided from each.

The pharmacy dispensed prescriptions issued by a private online prescribing service via a separate website 'manbehindthemirror'. The prescribing service website did not make clear that the service was provided by a GMC registered doctor, and it did not provide details about which pharmacy would supply the medicines.

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

Summary findings

The pharmacy has some safeguards in place to help it supply medicines safely. But the safeguards are not always effective and pharmacy policy is not always applied to control sales as intended. The pharmacy asks questions before it sells medicines so it can check whether they are suitable. But it sometimes supplies medicines more frequently than should be necessary, or in larger quantities, without checking whether there is good reason.

Inspector's evidence

The pharmacy's website provided details about how people could contact the pharmacy. This included an electronic contact form and a telephone number. Over-the-counter medicines were listed under the conditions they were used for. When a medicine was selected the website displayed information about how it was used and how it worked. But there was no general advice about the various conditions and no links to advice websites about healthcare conditions. This means people using the site may not have access to information that could be helpful.

When a person wanted to buy a medicine from the pharmacy's website, they were required to complete a questionnaire that was intended to determine whether the medicine was suitable for them. The questions asked were specific to the chosen medication. But the questions were usually closed with no opportunity to add any additional comments, and generally limited to three to five questions per medicine. This meant that the answers may not always fully explain the person's reason for wanting the medicine. The pharmacy manager said for some medicines, such as oral contraceptives, she would email the patient separately with the questions copied from manufacturer's guidance. An example of this was seen for a recent order for 'Hana Oral Contraceptive'. The pharmacy sold fluconazole as a treatment for fungal infections. Records showed it was one of the top 10 items sold on the website. The questionnaire for fluconazole stated 'This product is to be used a maximum of twice in six months. If you require this item regularly, please confirm if you are taking this item according to your GP advice and supervision.' But the pharmacy had provided up to 6 treatments at a time on some orders, which was in conflict with this statement. The pharmacy manager explained that this was because they would have assumed that the patient's sexual partner may also require treatment. But there was no additional questioning to confirm this assumption or explore the request further. The records also showed that a number of patients had been supplied with repeat orders of fluconazole 150mg capsules of up to 5 doses within a 6-month period.

Records of medicines that had been sold were held on an electronic dashboard, so that they could be reviewed by a pharmacist. The pharmacist described how she would check the answers provided to the questions, the person's order history, and complete the ID checks. This was a manual process for which the pharmacist would check the delivery address matched that of the billing address for the payment card and the IP address. If the pharmacist was satisfied the purchase was suitable, they would approve the order, which then enabled staff to print the order for picking.

A number of orders were seen to be 'on hold' which meant they would not be dispatched until after a date specified by the pharmacist. Some of these orders were for codeine-based products. When questioned, the pharmacy manager explained that this would happen when a patient had requested a repeat order too early. Any subsequent orders which were deemed 'too early' by the pharmacist would

be cancelled.

If a patient selected an answer which caused the pharmacist to think the medicine may not be appropriate, the pharmacist would email the patient to clarify the answer. For example, a patient had requested hydrocortisone cream and indicated it was for a person under 12 years old. After querying the answer with the patient, the response from the patient indicated this was incorrect and it was for an adult. But there was no further scrutiny. The pharmacy had a rejected sales log. An example seen was for an oral contraceptive purchased by a male. The pharmacist said she had rejected the order which automatically refunded the sale. A note contained the reason for rejection, in this instance it was because the pharmacy had a policy not to sell any oral contraceptives or emergency hormone contraceptives to a male.

Stock was arranged by a stock management program with designated locations. The labels would identify the location of the stock and the amount required. The stock would be picked in accordance with orders received and placed in a basket. Baskets were then placed on a bench for a check by a dispenser, before being packaged by operational staff ready for despatch. The person packaging the medicine would stamp the printed order to provide an audit trail.

People who used the 'manbehindthemirror' website would complete an online questionnaire with questions about their chosen condition. The questionnaire used an algorithm flow and if an incorrect answer was selected, the consultation ended. The website would then indicate to people to restart the consultation if they felt they had selected an incorrect answer. So it could be possible for people to re-submit after deliberately changing their answers in order to get a medicine they wanted. It was not known whether the prescriber would be aware if this had happened. The answers were reviewed by a UK based GMC registered doctor, who would then decide whether to issue a prescription. The pharmacy said the service was not required to be registered by CQC, but they could not explain the reason for this. The service used a LexisNexis identify checking service to check people's identity against the information provided in the questionnaire. As part of the consultation, people were asked whether they wanted their GP to be informed. But the pharmacy was not aware how many people would opt-in to share their information with their GP. The prescribing service issued paper prescriptions, but a scanned copy was sent to the pharmacy for them to dispense against. The original prescription was then received some time later. The private prescription records showed that a number of patients had received repeat orders within a short space of time. Some of these orders were supplied with 28 days' worth of medication in the first instance then a further 28 tablets had been prescribed and supplied six days later. There was no record of the reasons for this, and the pharmacy had not questioned whether the prescriptions were appropriate.

Medicines were packaged and sent using a variety of couriers, such as Hermes and Royal Mail. Tracking was used as an audit trail of where the medicine was, and a signature was required from the recipient to confirm receipt.

Medicines were obtained from licensed wholesalers. Stock was date checked on a 3-month basis. A date checking matrix was signed by staff as a record of what had been checked, and short-dated stock was highlighted in a diary for it to be removed at the start of the month of expiry.

There was a clean medicines fridge with a thermometer. The minimum and maximum temperature was being recorded daily and records showed they had remained in the required range for the last 3 months. Unwanted medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. Any alerts which required action would be recorded, with the details about who dealt with the alert and when.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. Equipment was kept clean. A forklift was located in the pharmacy premises. The director confirms he had the necessary forklift training and license to operate the machinery and only permitted staff were allowed to use it.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy.

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.