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: 11/03/2024

Pharmacy context

This is an online pharmacy situated in a warehouse near to Preston City Centre. People access the pharmacy using the website http://ayp.healthcare. It sells pharmacy only (P) and General Sales List (GSL) medicines to people through its website and delivers them using national couriers.

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	1.4	Standard not met	The pharmacy does not manage complaints in an effective and timely manner. There are delays in responding to people about their complaint. And this also means the pharmacy may not always identify learning opportunities from the concerns raised.
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 not all met

Summary findings

The pharmacy generally identifies the risks associated with its services and has written risk assessments. Its team members follow written procedures to help services be provided safely and effectively. The pharmacy keeps the records it needs to by law. But it does not always manage complaints and feedback in an effective or timely manner. Which means there are delays to people receiving a response about their complaint, and team members may miss learning opportunities from the concerns which are raised.

Inspector's evidence

Following a number of complaints from people who had ordered their medicines but had not received the delivery of their orders, an inspection of the pharmacy was completed. This was due to a systemic failure on the courier's part, which was not promptly identified by the pharmacy. A number of deliveries had not been delivered to people who had placed an order using the pharmacy website. The pharmacy had not identified the medicines which had not been delivered and relied on reactively responding to any complaints received. Due to the large volume of the complaints, the pharmacy asked for complaints to be raised by an email or through the pharmacy website.

There was a set of standard operating procedures (SOPs) which had been recently updated by the superintendent pharmacist (SI). SOPs were available to view on electronic software and were accessible by members of the team. An electronic record was kept which showed when team members had read and agreed to the SOPs.

A risk assessment had been completed for the services provided by the pharmacy and it identified controls which had been implemented. For example, having written procedures for the sales of medicines. The pharmacy had also conducted a risk assessment of each 'pharmacy only' medicine (P medicine) it sold through its website. To help manage the risk associated with selling some P medicines online, the pharmacy had restricted the quantity a person could purchase over a set time period. For example, loperamide was restricted to two boxes of 30 capsules in a one-month period. And laxatives required a review after two purchases in a six-month period to help reduce the risk of misuse.

The SI completed random checks on some of the orders which had been approved and completed by other pharmacists to see whether or not they were in-line with the procedures. But there was no wider audit to help review these checks in a formal and consistent manner. So, some learning opportunities may be missed. The pharmacy had systems in place to record and investigate any errors which had not been identified before an order was dispatched. However, the pharmacy was not aware of any errors which had occurred.

The roles and responsibilities of the pharmacy team were described within individual SOPs. There was an SOP regarding what can or cannot be conducted during the absence of a pharmacist. The pharmacy had a complaints procedure. The pharmacy was directing people to raise complaints via email or their website to help them handle the number of complaints which had been received around missing deliveries. The response time for the pharmacy to reply to people had been a few weeks. This meant there was a delay in the pharmacy being able to identify any issues which needed to be addressed to help improve their service. The delays in the pharmacy's response meant numerous negative reviews

had been left online.

A current certificate of professional indemnity insurance was seen. The correct responsible pharmacist notice was on display in the pharmacy and on its website. The RP record appeared to be suitably maintained.

An information governance (IG) policy was available and had been read by members of the team. Confidential waste was separated and destroyed by a waste carrier. A notice on the website provided information about how the pharmacy handled and stored people's information. Safeguarding procedures were included in the SOPs. Registered members of the team had completed level 2 safeguarding training. Members of the team would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them develop their skills. But it is not structured, so learning needs may not always be identified or addressed.

Inspector's evidence

There was a pharmacist, who was also the SI, two dispensers, one of whom was in training, and three medicine counter assistants, two of whom were in training. All members of the pharmacy team were appropriately trained or on accredited training programmes. Staffing levels were maintained by part-time staff and a staggered holiday system.

Two of the medicines counter assistants had recently been employed to help cope with the customer service workload. Their main role was handling customer queries and complaints due to the large number of complaints received. Following a formal complaint, the SI had identified the need for team members improve on their interactions with people. To address this, all members of the team were completing a training course about customer service skills.

A whistleblowing policy was in place. There were regular team meetings which also involved a number of locum pharmacists, and other pharmacy branches owned by the company. They discussed policy and governance topics and identified actions to help improve the service they offered. Records of the team meetings was kept for future reference. There were no professional based targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. And the pharmacy's website effectively informs people about who provides the services.

Inspector's evidence

The pharmacy had a website which people used to access its services. The website displayed the GPhC logo which was linked to the pharmacy's register entry. It also showed who the superintendent pharmacist was, and details about the pharmacy's ownership.

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

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages and provides its services safely. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. The pharmacy is accessible using electronic means. But the lack of a telephone may prevent some people making contact with the pharmacy. And the recent delivery failures mean services are not always provided in an effective manner.

Inspector's evidence

The pharmacy's website signposted people to get in touch with the pharmacy team by electronic messaging or email. The telephone number was on display. But due to the volume of telephone queries being received by the team, the phoneline had been switched off with a voice message directing people to the website.

People used the website to order 'Pharmacy-Only' medicines, GSL medicines, and pharmacy sundries. People could not order more than the restricted quantity of active ingredients which had been identified as high risk in the risk assessment due to safeguards built into the website. A warning under pharmacy-online medicines reminded people that they would need to answer some questions to help the pharmacist to decide whether the medicine was suitable. Each set of questions were bespoke to the product, and this had been identified as part of the pharmacy's risk assessment. The questionnaire asked people about themselves, their health, symptoms and gained confirmation about the safe use of the medicine.

The online orders received were placed in a queue for review by a pharmacist. The system would highlight any orders where there may be a duplicate account, or if there had been a previous order in the past 28 days. This prompted the pharmacist to review the information as part of their checks to make sure the sale of a medicines was done safely. The pharmacist sent a direct message to people if they had a query about some of the information which they received. And this was recorded on the person's account for future reference. One of the questions within the questionnaire asked if people would like additional information from the pharmacist. If this was selected, the pharmacist provided extra signposting information about their condition or treatment.

A rejected medicine list contained reasons for any orders which had been refused by the pharmacist. There was a large volume of rejections which indicated medicine requests were being reviewed appropriately. Some of the reasons for rejection included off-license use of fluconazole oral capsules for fungal skin conditions. And off-license use of hydrocortisone in psoriasis. As part of rejecting the sale of a medicine, people were signposted to an appropriate healthcare provider so they could access the support they required.

To help reduce the risk of inappropriate sales, the pharmacy required people to create an account on the website. When an account was created, the website used software to confirm the identity of people. For example, the software helped to make sure the account details matched the billing address. And the software rejected the creation of accounts for people who already had an account on the website to prevent duplicate accounts being used to make multiple purchases of medicines.

The pharmacy used a national courier with different levels of tracking depending on the order value of the products. Recently, the pharmacy had an issue with their courier provider, which resulted in a large number of lost or undelivered items. Some of these orders could not be traced by the pharmacy. The pharmacy has since found a new courier provider and normal services have been resumed.

Medicines were obtained from licensed wholesalers. The expiry date of medicines was checked every three months. A date checking matrix was signed by team members as a record of what had been checked. Designated waste bins were available to destroy any expired or damaged medicines. Drug alerts were received by email from the MHRA. The pharmacist read the alerts before they actioned them. But there was no record to help show the pharmacy was taking appropriate action.

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

Team members had access to the internet for general information. This included access to the British National Formulary (BNF), BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order.

The pharmacy used an electronic robot to help assist with the workload and a maintenance schedule was in place. As people did not visit the pharmacy in-person, there were adequate measures in place to help maintain confidentiality. A cordless phone was available in the pharmacy which allowed team members 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.