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: 17/10/2024

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 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 generally identifies the risks associated with its services and has written risk assessments to help show what action it takes to try and make its services safer. Its team members follow written procedures to help provide services safely and effectively. The pharmacy keeps the records it needs to by law. And it takes action to change its complaints handling process to improve the timeliness of how it responds to the complaints it receives.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which had a stated date of review in July 2025. 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 risks 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. But the pharmacy did not record specific details about the risks they were addressing which would justify their decision to restrict the number of packs that could be sold.

The superintendent pharmacist (SI) completed monthly audits about its online service to check it is operating as expected. For example, the products sold, the quantities permitted, and the time lockout period. 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 about what can or cannot be conducted during the absence of a pharmacist. And a member of the team correctly explained their understanding of this. The pharmacy had a complaints procedure, with details on their website. Complaints were received by email and reviewed by members of the team. To help improve the response time to complaints, a dedicated member of the team had been delegated to handle queries and complaints. The pharmacy showed records of its current complaints, and how it responded to previous ones it had received. The records indicated the pharmacy were now providing responses in a timely manner.

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 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. The pharmacist 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 superintendent pharmacist (SI), and three medicine counter assistants. 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. The pharmacy also used regular locum pharmacists to provide professional cover.

The SI conducted observational checks on tasks being performed by members of the team and any advice or areas of improvement were shared afterwards. But these observations were not documented to show what learning had taken place. Additional learning was not provided to team members, which would help to ensure learning needs were met.

A dispenser felt well supported by the SI and were able to ask for further help if it was needed. A whistleblowing policy was in place. There previously had been team meetings involving 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 were kept for future reference. But these had not been completed since February 2024, which meant the pharmacy may not be considering any recent issues that need addressing. 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 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.

Inspector's evidence

The pharmacy's website signposted people to get in touch with the pharmacy team by electronic messaging or email. But there was no telephone number available for people to contact the pharmacy on. So it may make it difficult for some people to contact the pharmacy. The pharmacy team explained that a telephone line was due to be installed in the near future.

People used the pharmacy's 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 medicines policy within the footer of each page reminded people that they would need to answer some questions to help the pharmacist decide whether the medicine was suitable. Each set of questions were bespoke to the condition of 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. But some of the questionnaires did not identify key red flags which would be helpful to the pharmacist in their decision making. The pharmacist acknowledged that these questions would be raised as part of the next review.

The online orders received were placed in a queue for review by a pharmacist. The system highlighted any orders where there may be a duplicate account, or if there had been a previous order. 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. Those who selected this option would be sent an email signposting them to an appropriate website.

A rejected medicine list contained reasons for any orders which had been refused by the pharmacist. These indicated medicine requests were being reviewed appropriately. Some of the reasons for rejection included off-license use of steroid cream on the face. Or the regular use of laxatives. As part of rejecting the sale of a medicine, people were signposted to the NHS website for further information so they could consider what 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 identify checking software to confirm the details against the software's database. 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. The couriers provided details of tracking so the pharmacy could follow up any medicines which had not been delivered. Deliveries to alternative addresses were permitted and had been risk assessed. To help control the risks associated with this, the website permitted only one alternative delivery address, and it flagged to the pharmacist when the delivery address had been changed so the pharmacist could review this information. There had been previous concerns raised due to delays in the delivery of medicines. A review of the pharmacy records indicated that the pharmacy was up to date with processing orders. The pharmacy had also contacted people to explain any delays, such as when there was a delay in the pharmacy receiving stock from their wholesalers and offered people a refund for their order. Following the inspection, the pharmacy had changed the type of delivery service, so all orders were sent using a tracked courier service. This helped the pharmacy to improve the level of customer service it provided people enquiring about delays in deliveries.

Medicines were obtained from licensed wholesalers. The expiry date of medicines was checked every three months. Records of short-dated medicines were kept. A medicines fridge was present with an in-built thermometer. The maximum and minimum temperatures were recorded daily and had been within the correct range for the past three months. The expiry dates of medicines were checked every three months. Records of medicines which were due to expire were kept so the medicines could be removed from the stock location. Designated waste bins were available to destroy any expired or damaged medicines. Drug alerts were received by email from the MHRA. The SI read the alerts and kept a record of any actions they had taken.

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 keep private information safe.

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.