General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Livve UK, 708a King Lane, Leeds, West Yorkshire, LS17 7AW

Pharmacy reference: 9011867

Type of pharmacy: Internet / distance selling

Date of inspection: 05/06/2023

Pharmacy context

This pharmacy is in a suburb of Leeds. People access its services through its website and contact the team by telephone and email. The pharmacy's main activity is prescribing and supplying medicines to treat the symptoms of menopause which is supported by two pharmacist independent prescribers.

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 suitably identifies and manages the risks associated with its services. It has up-to-date written procedures and prescribing policies that the pharmacy team uses to provide its services. And it generally completes the records it needs to by law. Team members have the knowledge to help protect vulnerable people and they suitably protect people's confidential information. They know how to respond when errors occur. And the pharmacists informally review each other's work. However, they don't extend this review to complete clinical audits. So, they may be missing opportunities to make services safer.

Inspector's evidence

At the time of the inspection the only service provided by the pharmacy was for the treatment of the symptoms of menopause. Two pharmacist independent prescribers (PIPs) including the Superintendent Pharmacist supported the service. And they worked within the guidelines produced by the British Menopause Society (BMS). A risk assessment (RA) for the service had been completed and the prescribing policies followed by the PIPs were underpinned by the latest BMS guidelines. The RA identified the operational risks and clinical risks associated with providing the service from a distance. These were mitigated by the PIPs undertaking a video consultation with people using the service. Another significant risk identified in the RA was the PIP responsible for prescribing the medicine may also be the pharmacist checking the medication dispensed from the prescription. So, the team ensured different PIPs were involved with prescribing and checking the dispensed medicine. To further support the safe and effective delivery of this service the pharmacy had standard operating procedures (SOPs) in place. These provided the team with information to perform tasks relevant to the service. Team members had read the SOPs but there was no evidence to show this such as a completed signature sheet.

The pharmacy began providing the service in October 2022, but it hadn't completed any formal audits of its service. The two PIPs worked closely and regularly informally reviewed each other's prescriptions to determine the clinical quality of the prescribing services and compliance with their own prescribing policies and risk assessments. But there was no record kept of these reviews. An SOP covered the management of errors identified as part of the dispensing process and those that were identified after people received their medicines. The team reported no errors had occurred since the service started as the range of medicines supplied was small and the dispenser was familiar with the medication prescribed. There was also sufficient time for dispensing the prescriptions before the medication was supplied, which helped with the accuracy of the process.

Comments left on social media platforms and online reviews were monitored by the team who responded to queries raised by people using the services. The comments were initially assessed by the dispenser in their role as operations manager so a prompt response could be sent. And any relevant actions were taken, for example when a person reported a damaged parcel this was shared with the delivery company. And an assessment on whether the product had been affected was undertaken by the pharmacists. Most concerns raised with the pharmacists were about medicinal patches falling off or the person having an allergic reaction to the patch. This led the pharmacist to prescribe an alternate product when appropriate.

Detailed records from the PIP's consultation with the person were kept. These included details on the symptoms the person was experiencing and other medical conditions the person was diagnosed with. The records also captured the advice given by the PIP and the medication prescribed, along with any interventions made by the PIP. The records were kept securely on the pharmacy's clinical system which was part of a secure clinical service platform primarily used for NHS services. These records were kept in addition to the supplies of medication which were captured separately on the pharmacy's electronic patient medication record (PMR). A separate online platform was used to create an account for the person and this was where invoices for the sales of the prescribed medication were generated and payments received. Copies of all the private prescriptions generated by the PIP were kept along with the accompanying private prescription register embedded in the PMR. A responsible pharmacist (RP) notice was not displayed at the time of the inspection and the RP log was missing several entries. The pharmacy had current indemnity insurance.

The pharmacy's PMR system and the other online platforms used by the team were password protected to help protect people's confidential information. People could read the pharmacy's privacy policy on its website and the team separated confidential waste for shredding onsite. The dispenser had completed data protection training.

The PIPs had up-to-date training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And the dispenser had completed training to understand their role in identifying potential safeguarding concerns. Team members had not had the occasion to report such concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with a good range of skills and experience to support its specialist service. Team members plan their work well, so people receive their medicines in a timely manner. They keep their knowledge and skills up to date with relevent training. And they work well together and support each other in their day-to-day work.

Inspector's evidence

Two pharmacist independent prescribers (PIPs) including the Superintendent Pharmacist (SI) who was also the pharmacy owner supported the menopause service which was provided three days a week. The PIPs generally worked on separate days but there was some overlap each week. A qualified dispenser who was also the operations manager supported the PIPs with administration tasks and arranging appointments. Dispensing of prescriptions only took place when one of the pharmacists was signed in as the RP. So, the team planned their workload from the date of the video consultations to the dispensing of the prescription to reduce any delays with the supply of the person's medication. At the time of the inspection the SI and dispenser were on duty. Team members worked well together and held weekly meetings to discuss workload and other matters such as feedback from people using the service.

Both PIPs were experienced in the treatment of menopausal symptoms and had knowledge and skills to safely deliver the service. They both had comprehensive learning portfolios and they had completed courses delivered by the BMS and the International Menopause Society. The PIPs had also completed training provided by an academy run by a specialist menopause clinic. The PIPs had access to medical peers who they could contact for support. And some of these medical peers had assisted the SI with developing the pharmacy's services. One of the PIPs worked part time for the local NHS Integrated Care Board (ICB) and was responsible for creating the ICB's clinical guidelines for menopause. The PIP was a member of a working group member responsible for creating a learning module on menopause for pharmacists completing their continued professional development (CPD).

The dispenser had opportunities to develop their knowledge through ongoing training and was given protected time at work to complete the training. They also had one-to-one feedback from the SI and had used these meetings to discuss enrolling onto the pharmacy technician course and becoming an accuracy checker.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriate for the services the pharmacy provides. And they are suitably clean, hygienic, and secure. The pharmacy's website is clearly laid out and professional in appearance which helps ensure people accessing its online prescribing service receive appropriate care.

Inspector's evidence

The pharmacy premises were kept clean, tidy and hygienic with separate sinks for preparing medicines and hand washing. Room temperatures were appropriately maintained, and the rooms were well lit. There was plenty of space for dispensing activity to take place and sufficient storage space for medicines and medicinal stock. A separate room was used for video conversations with people and enabled private conversations to take place.

People accessed the pharmacy's services through its website which was professional in appearance and straightforward to use. And it used several social media channels to promote its services. People were provided with clear information on how to access the service and could view details of the Superintendent Pharmacist and other team members. There was no option on the website to choose a prescription-only medicines before starting a consultation.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from recognised sources. And it manages and stores them appropriately. The team carries out suitable checks to make sure medicines are in good condition and safe to supply. The pharmacy generally manages and delivers its service as it should. And it reviews and monitors people's treatment. But more could be done to engage with people's regular prescribers so they can better monitor people's ongoing treatment and provide seamless care.

Inspector's evidence

The public could not directly enter the pharmacy to access services. Its website provided information on the services offered and the email and telephone contact details of the pharmacy. Telephone calls made when the pharmacy was closed were redirected to the pharmacists' mobile telephones. The website listed four services but at the time of the inspection only the menopause service was provided. This may be confusing for people accessing the services.

Information on menopausal symptoms was detailed on the opening page of the menopause section on the website. People new to the service were asked a few general questions about their symptoms and the answers were assessed by one of the PIPs before a video consultation was arranged. The video consultation enabled a two-way interaction between the person and the PIP where a medical history was taken using a consultation template the PIPs had created. The template was based on BMS guidance and acted as a further aid to complement the PIP's professional decisions. People were asked to confirm their name and date of birth at the beginning of the video consultation. Verification of the person's identity was not sought during the consultation, but the pharmacy's PMR system had a feature which synchronised a person's demographic information with their NHS number and GP surgery. This provided some assurance that the person was who they said they were. The pharmacy verified a person's identity when payment for the consultation and medication was made.

Consent to notify a person's GP was requested during every video consultation but most people declined. This made it difficult for the person's GP to have complete access to all the person's medical history and to monitor the persons long-term treatments. The PIPs explained to the person the importance of sharing this information. But reported many people were reluctant as they'd had challenging experiences in accessing menopause treatments from other healthcare settings before contacting the pharmacy. The pharmacy had systems in place to monitor people's menopause symptoms and the treatments prescribed. People were contacted by the PIPs within a few weeks of starting the treatment to check there were no problems with the medication and their symptoms were improving. The PIPs limited the supply of menopause medication to a maximum of 12 weeks to ensure there was an appropriate timescale for the benefits of taking the medication to be noticed. And to enable a timely clinical review to take place. The operations manager used the pharmacy's online account platform to schedule a time to contact the person to arrange the review which was conducted via a video consultation. When the person didn't respond a further email was sent. The SI reported everyone had responded to the invite for a review but some had replied to say they were leaving the service as they were receiving treatment from their GP. And a record of this was kept. People new to the treatment were provided with detailed information on the medication prescribed for them. This was at the time of the consultation with the PIP. And via links embedded in the email sent to the person confirming the medication prescribed and the invoice detailing how to make payments.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. There were checked by and dispensed by boxes on the dispensing labels to record who in the team had dispensed and checked the prescription. The two pharmacists clinically checked each other's work as a part of the dispensing process. The pharmacy used a recognised delivery company which enabled the team to track the supply of people's medicines. This included a photograph of the medicines being handed over to the person in case queries arose. A separate record of deliveries was kept by the team who contacted people to advise when to expect the delivery. Notification of a failed delivery was sent to the person who contacted the delivery company to arrange a re-delivery.

The pharmacy obtained its medicines from a reputable source and little stock was held. The dispenser regularly checked the expiry date of stock but didn't keep a record of this activity. And expiry dates on stock were checked during the dispensing and checking of prescriptions. No out-of-date stock was found. The pharmacy had a domestic fridge for storing medicines but none of the prescribed medicines dispensed at the pharmacy required storage at these temperatures. The team monitored the fridge temperatures to ensure the fridge was operating within the correct range. So, it would be ready to hold such stock when required. Legally compliant controlled drugs cabinets were in place but the pharmacy didn't currently hold such medicines. Appropriate arrangements were in place to handle medicinal waste. The SI received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) and received details when stock shortages triggered a national serious shortage protocol. This meant the PIPs would prescribe less quantities to people to ensure everyone received some of the medication whilst there was an issue with stock availability.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure it uses its equipment appropriately to protect people’s confidential information.

Inspector's evidence

The pharmacy had reference resources and access to the internet to help provide the team with up-to-date clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. Video consultations were conducted via a secure platform and the pharmacy computer was password protected.

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.