victorian pharmacy authority

Communiqué

3 May 2017

The Victorian Pharmacy Authority (the "Authority") met on 11 April 2017 at the Authority offices.

Some serious common deficiencies (reproduced from the April 2017 Circular)

Failure to scan or irregular scanning

Certain deficiencies are commonly noted during inspections of pharmacies in Victoria. A serious deficiency with high risk consequences is the failure to scan routinely all dispensed medicines. Given the well-known problems associated with "look-alike sound-alike" products as well as selection errors and storing products where the first few letters are the same, it is surprising that some pharmacists do not take full advantage of the scanning technology.

A pharmacist in Northern Ireland received a four-month prison sentence suspended for two years for supplying propranolol instead of prednisolone. Under United Kingdom law, a dispensing error is a criminal offence. The error resulted in the death of a 67-year-old mother of seven. The prescribed initial direction was for eight prednisolone tablets but the patient took eight propranolol tablets 40 mg. The tablets were side by side on a shelf and had similar branding.

Note: The particulars of this case are remarkably similar to the Elizabeth Lee case in England in 2007. Not only were the same drugs mixed up but unsatisfactory working conditions in the pharmacies were regarded as contributing factors. It is not known whether a bar code scanner was used in this case which is under investigation by the Pharmaceutical Society of Northern Ireland.

Not reconciling regularly Schedule 8 stocks and records

The increased prescribing of Schedule 8 poisons, the greater range of products and strengths are reasons why the register – electronic or manual – should be reconciled regularly against stock on hand. There is no mandated frequency for conducting S8 inventories but pharmacies that have heavy usage patterns should carry out stock checks more often. Many pharmacists check remaining stocks of a drug after they have removed the container from the safe and mark the balance with a tick if a manual register is used. Electronic registers will show when the last stock check was made. Unresolved discrepancies should be reported to the proprietor or pharmacist regularly and usually in charge, the Department notified in accordance with regulation 43, and all relevant actions documented.

Future inspections

Based on the relative high frequencies observed during inspections in the previous quarter, inspectors will be paying close attention to the following high risk areas in forthcoming inspections:

- adequacy of references
- appropriate storage and display of S3 medicines including S3 codeine
- direct alarm sensor coverage of S8 safes
- appropriate storage of pseudoephedrine products
- reconciliation of S8 stocks and records
- routine barcode scanning of items at the time of dispensing

Recent Panel Hearings

The Victorian Pharmacy Authority held five Panel Hearings in March 2017 into allegations that licensees had failed to meet their responsibilities to comply with the Pharmacy Regulation Act 2010 and/or good pharmacy practice at registered premises.

Case 1

A pharmacist was cautioned for having previously certified that several matters that had been rectified but were not, on subsequent inspection, found to have been remedied. These were unsatisfactory security of keys, inadequacy of alarms and storage of Schedule 2 poisons. The Panel also found that mandatory references had not been kept up to date, Schedule 3 codeine products were improperly displayed and there were labelling deficiencies associated with compounded medicines. There was inadequate provision for handling hazardous substances used in extemporaneous dispensing.

Case 2

A pharmacist was cautioned for having previously certified that keys were secure, that certain privacy-related issues had been resolved and that documentation of opioid replacement therapy was adequate; these items recurring at a subsequent inspection. Barcode scanning was found to be inadequate, workloads exceeded those laid down by the Pharmacy Board of Australia, the alarms were inadequate, Schedule 3 poisons were displayed in a manner contrary to the Drugs, Poisons and Controlled Substances Regulations 2006 and the dispensing balance did not meet standards.

Case 3

The proprietors of a pharmacy were cautioned following a hearing where the Panel found that transactions in Schedule 8 poisons were not carried out in a timely manner and records of Suboxone were deficient. Filling records for dose administration aids were not maintained and mandatory cautionary and advisory labels were not applied to them. Records that contained confidential information were not disposed of appropriately.

Case 4

An allegation was made that the keys to a pharmacy were kept by a person who was not a registered pharmacist. The Panel found the allegation unsubstantiated and took no further action.

Toni Riley
Chair
3 May 2017