



## Communiqué

15 January 2016

The Victorian Pharmacy Authority (the Authority) met on 12 January 2016 at the Authority offices.

This communiqué from the Authority contains a message to licensees about the importance of maintaining written operating procedures in pharmacies and a summary of recent Panel Hearings.

### Written operating procedures

The Authority frequently notes that pharmacies lack adequate written operating procedures when pharmacists are requested to attend Authority meetings to discuss inspections or during Panel Hearings.

The Authority reminds pharmacy owners of their responsibilities as the holder of a pharmacy business licence and advises that in order to be able to effectively discharge those responsibilities it is essential that up-to-date written operating procedures are maintained at the premises.

Quality written operating procedures are an important tool for the provision of safe, consistent and effective pharmacy services. As a pharmacy owner, would you be confident that there are sufficient written procedures available at your pharmacy to enable a locum pharmacist to step in at short notice and run the pharmacy safely and confidently in your absence, or the absence of the pharmacist regularly and usually in charge? This is a good test of whether your procedures are up to scratch.

Procedures should be relevant and tailored to the operations of the pharmacy. They should be concise, accessible and capable of being carried out.

Authority pharmacists frequently note insufficient written operating procedures in the following areas:

- Complex compounding
- Opioid replacement therapy
- Refrigerator temperature monitoring (the Authority's Guidelines now include an appendix on the subject; see <http://www.pharmacy.vic.gov.au/index.php?view=guidelines> page 32)

### Panel Hearings

During December, six Panel Hearings were held into allegations that licensees had failed to meet their responsibilities.

Once again, hearings involved matters relating to inadequate storage or records for Schedule 8 poisons. The Authority considers deficiencies relating to Schedule 8 poisons to present an unacceptable level of risk to the public and continues to conduct Panel Hearings when such deficiencies are noted.

Selected Panel Hearing deficiencies and outcomes are summarised below.

#### Case 1.

The proprietor was found to have failed to comply with the Act and/or there was a failure of good pharmaceutical practice at the registered premises, in that there was:

- Failure to ensure that records of all transactions in Schedule 8 poisons showed the true and accurate balance of each Schedule 8 poison remaining in their possession after each transaction;
- Failure to store Schedule 8 poisons in a Schedule 8 poisons safe;
- Failure to submit quarterly self-audits in accordance with an existing licence condition.

The Panel reprimanded the proprietor and determined that the premises be re-inspected at the proprietor's cost, the fee being \$314.50.

*Case 2.*

The proprietor was found to have failed to comply with the Act and/or there was a failure of good pharmaceutical practice at the registered premises in that there was:

- Failure to ensure that records of all transactions in Schedule 8 poisons showed the true and accurate balance of each Schedule 8 poison remaining in their possession after each transaction;
- Failure to maintain prescription reception and counselling points fitted with privacy screens;
- Failure to make adequate arrangements during the transfer of dispensed medicines to the cash and wrap counter, and at the cash and wrap counter, to ensure that the identity of a medicine being supplied or dispensed to a client of the pharmacy remains private and confidential;
- Failure to monitor the drug refrigerator with a temperature data logger.

The proprietor was reprimanded.

*Case 3.*

The proprietor was found to have failed to comply with the Act and/or there was a failure of good pharmaceutical practice at the registered premises in that there was:

- Failure to ensure that records of all transactions in Schedule 8 poisons showed the true and accurate balance of each Schedule 8 poison remaining in their possession after each transaction;
- Failure to store Schedule 8 poisons in a Schedule 8 poisons safe;
- Failure to maintain prescription reception and counselling points fitted with privacy screens;
- Failure to make adequate arrangements during the transfer of dispensed medicines to the cash and wrap counter, and at the cash and wrap counter, to ensure that the identity of a medicine being supplied or dispensed to a client of the pharmacy remains private and confidential.

The proprietor was reprimanded.

Toni Riley  
Chair