Communiqué

29 June 2017

The Victorian Pharmacy Authority (the "Authority") met on 13 June 2017 at the Authority offices.

Performance measurement framework

The Authority is implementing a publicly available performance measurement framework.

The purpose of the framework is to provide information on the Authority's activities and intended outcomes.

The document is being circulated with this communiqué and includes the Authority's first quarterly performance report for the period 1 January 2017 to 30 March 2017. It will also be made available on the Authority's website.

Panel Hearings

In May 2017, the Authority held five Panel Hearings 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, summarised as follows:

Case 1

In this case, the licensee was reprimanded for failing to install a monitored security alarm system in a new pharmacy. There was also no approved weighing equipment in the dispensary and prescription reception and counselling points did not meet the requirements of the guidelines. Schedule 3 poisons were not displayed appropriately and the Schedule 8 safe was used for the storage of items other than drugs of dependence.

Case 2

The licensee was cautioned for not ensuring that the identity of a medicine supplied to a patient could not be known by other persons as required by the Act; failure to identity the person carrying out transactions in Schedule 8 poisons; not recording transactions in S8 poisons in a timely manner; discrepancies in the S8 register when compared with stock on hand; inadequate barcode scanning, absence of a temperature data logger in one refrigerator and not having a procedure to identify breaches of the cold chain.

Case 3

The licensee was reprimanded. There was improper storage of S8 poisons and discrepancies in the recording of them; failure to undertake routinely barcode scanning; not maintaining an up-to-date library; and the absence of a temperature data logger and a procedure to identify breaches in the cold chain.

Case 4

A caution was issued to licensees who failed to store S8 poisons as required by the regulations; unsatisfactorily recording of pharmacotherapy transactions; not maintaining an up-to-date reference library; and not displaying the name of the duty pharmacist.

Case 5

The licensees were cautioned following evidence of discrepancies in S8 transactions and not securing the S8 safe adequately. Dispensing balances and measures were unsatisfactory and inadequate. References were out-of-date. There were no procedures for inter-staff professional communications and temperature monitoring. The name of the licensee was not displayed in the approved manner.

Toni Riley
Chair