



## Communiqué

22 March 2016

The Victorian Pharmacy Authority (the Authority) met on 8 March 2016 at the Authority offices.

This communiqué from the Authority contains a message to pharmacy owners about privacy and a summary of recent Panel Hearings.

### Privacy

Many pharmacists still do not make adequate arrangements for consumer privacy in their pharmacies. Pharmacy is unique in that the profession is practised in full view of the public.

The identity of a medicine being supplied or dispensed cannot be known by another client of the pharmacy or pharmacy department, and where this occurs pharmacies are operating in contravention of the *Pharmacy Regulation Act 2010* (refer Schedule to the Act, clause 9(h)).

Adequate arrangements must be in place to (a) ensure that confidential discussions can occur between pharmacists and their clients in privacy, and that third parties do not see a patient's medicines, and (b) the identity of patients' medicines is kept private during transit to, and at the cash and wrap counter.

Privacy-related complaints now comprise a significant proportion of complaints to AHPRA. Pharmacists should frequently put themselves in the place of the consumer as they move around their pharmacies in order to identify where privacy breaches may be occurring. Refer to VPA Guidelines for details regarding privacy and privacy screens.

There are still instances where the carrying of open baskets containing dispensed medicines to a remote cash register enables other people to identify a patient's medication. Pharmacy owners have a statutory obligation to ensure that arrangements are in place to prevent inadvertent disclosure of this kind.

If the dispensed medicines are to be transferred to the final bag at the cash register, arrangements are necessary to maintain privacy during the transfer.

Pharmacists should also ensure that adequate procedures are in place to ensure that confidential waste is not disposed of in general waste. Inspectors frequently see unwanted repeat authorisations, dispensing labels and dose administration aid material and header cards amongst general waste.

### Panel Hearings

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

The Authority continues to convene Panel Hearings where serious deficiencies relating to recording or storage of Schedule 8 poisons have been identified during inspections. Deficiencies and outcomes from a selection of hearings 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 record transactions in Schedule 8 poisons as soon as practicable;
- Failure to store Schedule 8 poisons in a Schedule 8 poisons safe;
- Failure to store Schedule 4 poisons in the dispensary or lockable facility;
- Failure to prevent the public from accessing the dispensary in that a consulting area was located in the dispensary;
- Supply of multiple repeats of prescription medicines simultaneously without the expressed approval of the prescriber;
- Provision of expired medicines to the public from a display stand within the pharmacy.

The proprietor was reprimanded and a condition placed on the proprietor's licence requiring quarterly submission of pharmacy self-audits to the Authority for a period of twelve months.

### 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 record transactions in Schedule 8 poisons as soon as practicable;
- Failure to maintain a pharmacotherapy procedure manual detailing the systems in place at the pharmacy;
- Failure to display the name of the pharmacist regularly and usually in charge of the pharmacy;
- Failure to dilute methadone take-away doses with water to a volume of 200mL.

Several of the matters had been the subject of previous disciplinary action. The proprietor was reprimanded and a condition placed on their pharmacy business licence requiring quarterly submission of pharmacy self-audits to the Authority for a period of twelve months. The Panel also ordered the premises to be re-inspected at the proprietor's cost, the fee being \$314.50.

### **Statistics**

On 11 March 2016 there were:

1349 pharmacies  
75 pharmacy departments  
30 pharmacy depots

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