The Pharmacy Guild of Australia

90 YEARS

25 May 2018

Ms Mikaela Meggetto
Coroner's Registrar
65 Kavanagh Street
SOUTHBANK VIC 3006

Email: cpuresponses@coronerscourt.vic.gov.au

Dear Ms Meggetto

Investigation into the death of Margaret A Yeomans Court Reference: COR 2016 003703

I refer to you letter of the 22 February 2018 regarding the following recommendation made by Coroner in respect of the above investigation:

> *I further recommend that the National Council of the Pharmacy Guild of Australia review the circumstances of Mrs. Yeoman's death, for the proposes of education, awareness and the creation of robust dispensing policies and guidelines.*

As you may be aware The Pharmacy Guild of Australia is the national peak body representing community pharmacy and is registered under the Federal Industrial Relations Act as an employers' organisation for the owners of community pharmacies. It seeks to serve the interests of its members and to support community pharmacy in its role delivering quality health outcomes for all Australians. The Guild is disappointed to learn of the circumstances of Mrs Yeoman's death and whilst we are not a regulatory body we take a keen interest in the quality of pharmacy practice in Australia.

As Guild is not a regulatory body it is not responsible for the creation of dispensing policies and guidelines.

We would advise that the Pharmacy Board of Australia has the responsibility of:

- registering pharmacists and students
- developing standards, codes and guidelines for the pharmacy profession
- handling notifications, complaints, investigations and disciplinary hearings
- assessing overseas trained practitioners who wish to practise in Australia
- approving accreditation standards and accredited courses of study.

The Pharmacy Board of Australia's Guidelines for dispensing of medicines are available at: http://www.pharmacyboard.gov.au/Codes-Guidelines.aspx

We would also point out that the Pharmaceutical Society of Australia (PSA) is the peak national professional pharmacy organisation representing Australia's 29,000 pharmacists working in all sectors and across all locations. The core business of PSA is practice improvement in pharmacy by providing continuing professional development and practice support, in order to improve the health of Australians.

The PSA has developed the 'Dispensing Practice Guidelines' (available at http://www.psa.org.au/practice-support-and-tools/guidelines-and-tools/dispensing-practice-guidelines) to assist pharmacists, intern pharmacists and pharmacy students to understand their professional obligations when dispensing medicines, and performing other associated tasks including brand substitution and the provision of Consumer Medicines Information (CMI). The Guidelines provide guidance on expected professional practice to provide optimal patient outcomes.

This guidance includes:

- appropriate and effective processes
- desired behaviour or minimum standards of good practice
- how duties and responsibilities may be best fulfilled.

In addition to the guidelines provided by the Pharmacy Board and the PSA we would also advise that Pharmaceutical Defence Limited (PDL) (the pharmacy professional liability insurance body) publishes a 'Guide to Good Dispensing Chart' which is based on the Quality Care Pharmacy Program (QCPP) and is designed to minimise the potential for dispensing errors. PDL also publishes the 'Dispensing Error Chart' that outlines procedures to follow in case of a dispensing error. We have recently received correspondence from PDL's CEO Mr David Brown who is aware of the coroner's recommendation and he has advised that PDL will provide the attached advice as a Practice Alert to the 20,000+ members of PDL. This will highlight to pharmacists the importance of reviewing their practice to ensure that when issues of concern are raised by a consumer the concern is referred to the pharmacist.

I have discussed this matter internally and we believe that, as outlined above, there are sufficient dispensing policies and guidelines for pharmacists and that it would be more appropriate for the Guild to concentrate on education and awareness of these guidelines and polices by using the Coroner's investigation as a Case Study. The Guild has a Learning and Development Group that could investigate the creation of an online learning module that would incorporate aspects of the case with a view to ensuring that pharmacists re-evaluate their practices and procedures.

The Guild Learning and Development platform 'MyCPD' is an online learning management system allows all pharmacists to further their knowledge and fulfil their professional development and CPD/QCPP refresher training requirements in one easy to use platform. All pharmacists in Australia have access to this platform free of charge and we currently have a large proportion of Australian pharmacists registered.

I trust this addresses the recommendation to the Coroners' satisfaction and that our offer to provide education will prevent other misadventures of this nature.

Yours sincerely

Trent Twomey
A/g National President

PDL PRACTICE ALERT

A CORONER'S FINDINGS

In a recent Coronial inquest, the Coroner found that a dispensing error made by a pharmacist was a contributing factor in the death of an elderly consumer.

A consumer with multiple health issues was wrongly dispensed rosuvastatin 40mg instead of the prescribed simvastatin 40mg tablets. The consumer was admitted to hospital where the error was subsequently discovered and rhabdomyolysis was identified. The cause of death was determined to be rhabdomyolysis.

In her recommendations from the inquest, the Coroner directed that the "Pharmacy Guild of Australia review the circumstances of the consumers death for the purpose of education, awareness and the creation of robust dispensing policies and guidelines".

All Australian pharmacists will be aware of the many published dispensing guidelines available which include the Pharmacy Board of Australia *Guidelines for dispensing of medicines*, the PDL *Guide to Good Dispensing*, the PSA *Professional Practice Standards* and the various dispensing protocols developed by the many pharmacy banner groups.

However, a critical failure in pharmacy practice was exposed which needs comment. The consumer's husband did in fact identify that the dispensed item appeared different to the usually supplied product. When asking about the discrepancy, an unidentified staff member said words to the effect of "it's alright, *maybe it's a different box".* It is highly probable that this person was a pharmacy assistant. Thus, an opportunity to carefully investigate the error was missed.

The lesson to be learned from this unfortunate chain of events is to always treat consumer concerns and queries seriously. PDL are aware of similar situations where consumer questions have been handled by unqualified staff instead of being referred to the pharmacist. A typical answer by unqualified staff is 'it may be just a generic version'.

To prevent such errors occurring, pharmacy managers should instruct their staff to refer all questions around medication to the pharmacist on duty. Such referrals should be carefully investigated by that pharmacist because, as this case demonstrates, the consumer's concerns may be justified.

Guide to Good Dispensing

This guide is based on the Quality Care Pharmacy Program. It is designed to minimise the potential for dispensing errors and to save you time and expense. A number of routine checks and procedures have been prepared for your guidance. You are strongly advised to observe them on each occasion you dispense a prescription.

1 Prescription Receipt

Provide the customer with an identifying docket or number, if available. Separate prescriptions for individual patients prior to dispensing.

CHECK:

Patient Details

- Name
- Address
- Phone or mobile number
- Any other contact
- Concessional entitlements
- Medicare number
- Allergies
- Date of birth
- Body weight

Prescription Details

- Date
- Doctor's signature
- S4 requirements
- S8 requirements
- Authority approval
- Advise substitution option

2 Computer Input

Input prescription details using either electronic identifier, e.g. barcode, or using the pharmacist's original copy of the prescription.

CHECK:

- **Prescription** data matches patient and prescription details.
- **Medication** profile for consistency of treatment and compliance.
- **Interactions**.
- **Evidence** of misuse.
- **Use computer software** to select and record any brand change.
- **Ensure** the prescriber's intended specific directions are printed on the label.
- **Generate** labels (one for each pack if multiple packs), repeat authorisations and CMIs where applicable.

3 Drug Selection

Using the pharmacist's original prescription document, select manually or robotically and check:

- **Drug**
- **Strength**
- **Quantity**

4 Labelling

Label each item CHECKING:

- **Expiry** date.
- **Directions** with those on original prescription document.
- **Drug,** strength and quantity against the pharmacist's original copy of the prescription.
- **Apply** appropriate cautionary and advisory labels.
- **Include** reference to generic substitution, e.g. "This replaces ...".
- **When** attaching label, do not obscure important information on manufacturer's label (especially name, strength, expiry date and batch number).
- **Ensure** identification of dispenser/checking pharmacist is included, e.g. record initials on the label and or prescription.

5 Label Check

Where possible, attach or partially attach the label to the product, scan the barcode on the label (if double scanning available), then scan the product. Ensure the dispensing program has confirmed the label and product are matched before proceeding.

- **For multiple item dispensing**, it is recommended to keep all items together in an appropriate container.

6 Assembling Prescription

Assemble dispensed medicines with all documentation and counselling aids.

- **Check** all items belonging to the prescription. Identify and/or set aside any items requiring intervention with patient or agent.
- **Place** in a container which leaves all items visible.
- **Store** finished prescription out of the reach of the public and so it is not identifiable by the public.

7 Final Check & Collection of Prescription

CHECK:

- **The drug**, strength and quantity against the pharmacist's original copy of the prescription.
- **Consider** if provision of other professional services is appropriate.
- **Identify** to staff (e.g. via laminate, tag or note) issues requiring specific advice such as generic substitution, clinical intervention, special storage requirements.
- **Provide** CMI if appropriate.
- **Verify** that the correct person is receiving the prescription by **ASKING the patient/agent to confirm** the name and address or cross-check if numbering system used.
- **Counsel** patient (consumer/client), with consideration to patient privacy.

PDL STRONGLY RECOMMENDS THE USE OF SCANNERS IN DISPENSING

Member login at **www.pdl.org.au** or call 1300 854 838 if you need advice or support in relation to an incident.

Your PDL membership including Professional Liabilities Insurance (PI) cover is due 30th April annually.