

PDL Practice Alert

Date of issue to pharmacist members: 20 July 2018



Pharmaceutical Defence Limited

ABN 51 004 065 794

P: 1300 854 838

E: info@pdl.org.au

www.pdl.org.au

Robust Dispensing Guidelines - Rosuvastatin

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 recommendations from the inquest, the Coroner directed that the "Pharmacy Guild of Australia review the circumstances of the consumer's 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 may be 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 are advised to 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.

[Link to: PDL Guide to Good Dispensing](#)

PDL membership includes 24/7 access to speak with a Professional Officer for immediate advice and incident support, Australia wide. Call 1300 854 838 if this topic raises any concerns for you or please leave a comment or question for our Professional Officers via the blog below.

[< PDL member portal blog >](#)

~ END ~