On **6 March 2024** the General Pharmaceutical Council's Investigating Committee considered an allegation in relation to **Mrs Nada Elia, registration number: 2053096** and determined to issue the registrant concerned with a warning in relation to the conduct alleged.

The Committee concluded that the appropriate outcome in this case is a warning with the wording of:

> This case relates to a registered pharmacist, Mrs Elia. At the time of the incident, Mrs Elia was working as the Responsible Pharmacist (RP) at Old Hill Pharmacy.
>
> On 15 May 2023 Patient A attended the pharmacy, on the advice of her GP, for a treatment for oral thrush. Patient A was clear when she spoke to a counter assistant that she was on Warfarin. A Daktarin oral gel treatment was checked with Mrs Elia, who was the RP on the day and working in the dispensary; she confirmed the supply. It should be noted that the Daktarin supplied is not an over-the-counter medicine but a P-medicine. A P-medicine is one that can be supplied without a prescription but the supply, may only be made under the supervision of a pharmacist who should confirm its suitability and use with the patient.
>
> Patient A again queried if the actual medicine being supplied was safe and, quite properly, the counter assistant again checked the medicine with Mrs Elia. Mrs Elia confirmed, without any further checks, that it was safe to use.
>
> However, as was clear from the packaging and medical resources easily accessible to Mrs Elia, the medicine is not safe to use for patients on Warfarin. It carries serious anti-coagulant risks for such patients and can lead to significant harm. Fortunately, Patient A's husband checked the packaging before she used it and the medicine was not used.
>
> Mrs Elia has readily accepted responsibility for what happened. She offered an apology when Patient A called and complained on the day and stated clearly that it was her oversight. However, in response to a further query from a GPhC case officer,

The Registrant confirmed that she was informed by Patient A about her Warfarin status, but she had "been told as well that the doctor asked the patient to buy over the counter which make me rely on the doctor awareness."

Notwithstanding the patient clearly articulating her contra-indicated status to Mrs Elia, and despite the patient querying a second time if it was safe, Mrs Elia was content at the time to supply a medicine on a simple assumption that the doctor's recommendation of a treatment required no further checks on her part. This was despite the fact that Mrs Elia was, in fact, supplying a P-medicine.

This was a serious failure on Mrs Elia's part to act in the patient's best interests by taking professional responsibility to supply a medicine only if it was safe to do so. In essence, Mrs Elia relied on an assumed assurance that the doctor must know best when, in fact, the patient was rightly seeking the professional assistance of a registered pharmacist to supply a medicine safe to use given her Warfarin status.

Mrs Elia has, by her conduct, breached the following GPhC Standards for Pharmacy Professionals:

- Standard 1 – All pharmacy professionals should provide patient-centred care
- Standard 2 – All pharmacy professionals must work in partnership with others
- Standard 5 – All pharmacy professionals must use their professional judgement
- Standard 6 – All pharmacy professionals must behave in a professional manner.

Mrs Elia is warned that it is her responsibility, at all times, to ensure a medicine is supplied only when it is safe to do so. It is her responsibility to carry out any checks necessary to assure herself, or a patient, that the medicine is safe in all the circumstances. Pharmacy professionals are not entitled to assume a medicine is safe.

Any similar conduct will be likely to result in further regulatory intervention.

The Committee directs that this warning as written above will be published on the register for a period of 12 months.