

On **3 December 2025** the General Pharmaceutical Council's Investigating Committee considered an allegation in relation to **Ms Fola MUSTAPHA, registration number: 2229270** 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:

On 7 December 2024 the Registrant, Fola Mustapha, was working as a Responsible Pharmacist and incorrectly dispensed an Espranor tablet (buprenorphine), a schedule 3 Controlled Drug to a patient, instead of a prescribed Ella One tablet (used for contraception). Fola Mustapha, failed to undertake proper identity checks prior to dispensing the incorrect medication to the Patient. The two medications were not look alike sound alike medicines and are used for completely separate treatments. Upon the error being discovered the Registrant failed to explain the possible side effects of consuming the wrong medication to the patient and provide safety netting. The Registrant also failed to report and escalate the matter to pharmacy staff as required in line with her duty of candour and GPhC standards. After consuming the wrong medication, the Patient suffered side effects including sickness, dizziness and nausea which necessitated her being attended by the ambulance service who administered medication to alleviate the side effects.

The above amounts to a breach of the following Standards for Pharmacy Professionals:

- *Standard 1 requires pharmacy professionals to deliver person-centred care and consider the impact of their practice.*

- *Standard 5 states that pharmacy professionals must use professional judgement, so that they deliver safe and effective care.*
- *Standard 9 states pharmacy professionals must demonstrate leadership including to assess the risks in the care they provide and do everything they can to keep these risks as low as possible.*

Fola Mustapha is warned to ensure all clinical and accuracy checks are completed to a high standard to ensure patient safety and public confidence are assured and to ensure that should a patient safety issue come about in the future that such matters are acted upon without delay. Any repetition of the same or similar failings is likely to result in more serious regulatory intervention.

This warning will be published on the register and will be available for 12 months.

That concludes this decision.