Annual Report of the Scrutiny Committee 2015

One of the obligations of the "The Council of the Pharmaceutical Society of Northern Ireland (Statutory Committee, Scrutiny Committee and Advisers) Regulations (Northern Ireland) 2012", is the provision of an annual report. The legislation states as follows;

7.—(1) The Scrutiny Committee has the following additional functions—
(a) providing an annual report to the Council in respect of each calendar year, by a date specified by the Council, which is to include
(i) trends, patterns and learning points observed from cases considered by the Scrutiny Committee,
(ii) details of the numbers of fitness to practise and disqualification allegations which
were disposed of by the Scrutiny Committee by means of warnings and undertakings
during that year, and
(iii) the reasons why the allegations referred to in sub-paragraph (ii) were not referred to
the Statutory Committee;

This is the third such report and covers the calendar year of 2015. The Scrutiny committee came into existence in late 2012, during which period training for all members was undertaken.

Composition of the Scrutiny Committee

The statutory Scrutiny Committee which sat during 2015, consists of a publicly recruited panel, trained in fitness to practise proceedings.

Chair and legally qualified member	Mr. John Gibbons
Deputy chair and legally qualified member	Ms. Rosemary Connolly
Lay member	Mr. Andrew Thomson
Lay member	Mr. Colin Kennedy
Pharmacist member	Mrs. Bronagh White
Pharmacist member	Prof. Colin Adair
Pharmacist member	Mr. James Taggart

Background

By way of background, following the enactment of new legislation in October 2012, additional powers enable the Pharmaceutical Society NI to take more proportionate approaches to the management of fitness to practise case outcomes, than simply removal from the register.
The new powers in regard to fitness to practise mean that as a regulator the Society can

- Give advice,
- Issue formal warnings,
- Agree undertakings,
- Place conditions on the practise of a pharmacist,
- Impose suspension,
- Issue interim orders and
- Remove registrants from the register.

Fitness to Practise Committees
Under the new legislation, two committees have been established which determine allegations regarding fitness to practise.

Scrutiny Committee (Initial Proceedings)
This committee considers initial allegations on a paper based format and it has the power to dismiss a case, give advice, issue warnings and agree undertakings if appropriate and refer more serious cases to the Statutory Committee (subject to threshold criteria).

Statutory Committee (Hearings Committee)
This committee considers allegations at hearings of misconduct of registered pharmacists. Registrants are invited to make representations with legal support if necessary. The Statutory Committee deals with all categories of alleged impairment referred to it by either the Registrar or the Scrutiny Committee and may utilise the full range of fitness to practise sanctions i.e. Give advice, issue formal warnings, agree undertakings, place conditions on the practise of a pharmacist, impose suspension and remove registrants from the register. It also deals with interim orders, restoration applications and review hearings.

The Work of the Scrutiny Committee, 2015

The Committee sat on six occasions dealing with a total of eight cases, in the full calendar year. A short summary of those cases is attached hereto at **Appendix one**, detailing the registrant, the date of hearing, composition of the committee panel, the category of complaint and the method of disposal.

To better understand the reasoning of the Scrutiny Committee, in such cases, the "Threshold Criteria" for referral to the Statutory Committee are set out in full at **Appendix two** hereto. These criteria guide the Scrutiny Committee as to how to assess which cases are more serious and deserving of consideration by the Statutory Committee. In each of the eight cases, a full reasoned written decision is provided by the Legal Chairperson setting out how these criteria have been applied in each case, after deliberation by the committee. In none of this year's

cases did the Scrutiny Committee conclude that the threshold for referral on to the Statutory Committee had been met. In each of the cases it was felt that the Scrutiny Committee was able to deal with those matters, using the powers granted to it by the legislation. Further information on those matters is necessarily provided later, in the section of this report that deals with Regulation 7(1)a(iii).

The Committee noted that it was able to deal with all eight cases without referral to the Statutory Committee, as occurred in 2014. We suspect that this reflects the developing experience of all involved in the disciplinary process and a growing understanding of the nature of cases that are so serious that they can and should be referred directly to the Statutory Committee. There may be cases in the future where the level of seriousness is unclear, and the Scrutiny Committee will consider them and decide that they do indeed require to be referred on to the Statutory Committee. However, that was not the experience in 2015.

THE STATUTORY PURPOSE OF THIS REPORT:

Regulation 7(1) a(i) : "Trends, Patterns and Learning Points"

As required by the legislation mentioned earlier, the first purpose of this report is to identify "trends, patterns and learning points" and bring these to the attention of the Council of the Society, with a view to enabling issues to be identified at as early a stage as possible.

Trends and Patterns:

The Scrutiny Committee was of the view that many of the cases referred to it, this year, involved dispensing errors of varying degrees. The particular trends and or patterns of behaviour that came to the attention of the Committee often involved the interplay between human error and SOPs. This would seem to be a perennial problem, and the comments below will no doubt require the Council of the Society to reiterate advice to the profession on such issues.

There was again one case involving "drink driving". However, this will inevitably occur when considering a body of people of the size of the profession, and the Committee could not say that they found any unusually high level of offending behaviour, of any particular category. There was one case of the inappropriate sending of text messages to a patient, considered to be unprofessional behavior from a Registrant. Another case involved the careless filling in of forms by a student Registrant who omitted to be fully honest in so doing. However, the conduct occurred in a period when QUB were responsible for dealing with misconduct, not the Society.

These cases highlight the diverse mix of cases that come before the Scrutiny Committee and again this year, it was impossible to discern any particular pattern of concern.

Learning Points

Each panel considering a case will comprise a Legal Chair, a Lay member and a Pharmacist member. The pharmacist members of each panel were asked to comment on any learning points they felt had arisen in each case they were involved in, as they were felt to be best placed to comment on what may or may not be the considered view of the average member of the profession. Other members were asked to put forward any points they felt may be relevant, from their more general experience. Below are a summary of the points made by committee members, as to what could be considered learning points, which were considered and gathered from the panel members at the end of each hearing, on the dates given. These are issues which may already be addressed in training and guidance given to the profession, but as they have arisen in the context of the caseload of the committee, these may be areas where further emphasis may be needed. That would be a matter for the Society to consider.

Learning points for the profession – recorded at Scrutiny Committee meetings in 2015

<u>Hearing date; 05-02-2015</u>

- Locums should be careful not to presume the facilities and SOPs are robust and should be vigilant.
- One should always be careful when making an emergency supply to check against the original prescription to avoid dispensing errors.
- Profession should be fully aware that they have a legal requirement to report any fitness to practise matters within 7 days of the date of occurrence to the regulator;
- Where relevant healthcare professionals are required to co-operate with health assessments were there are issues of potential impairment.

<u>Hearing date 11-05-2015</u>

- The Committee highlighted one should always be careful when making an emergency supply to check against the original prescription to avoid dispensing errors.

Hearing date 02-09-2015

- Student Pharmacists should be scrupulously honest when completing froms that will be considered when admitting someone to the profession
- Students should realise that their conduct, when still students and even when not directly linked to their studies, can have grave consequences for their career;

Hearing date 22-10-2015

- None - case was dismissed

Hearing date 12-11-2015

- In cases where there has been a conviction for drink-driving, registrants can expect to be referred to the Statutory Committee unless the following factors apply:

  i. It's a first offence;

  ii. There are no apparent aggravating factors e.g. harm to others; excessive levels of alcohol in breath or in blood etc;

  iii. There is a level of insight exhibited by the registrant;

  iv. Medical evidence does not highlight a alcohol issue.

Regulation 7(1)a(ii): "Details of disposals by warnings and undertakings"

As required by the legislation mentioned earlier, the second purpose of this report is to identify those cases where the Scrutiny Committee felt able to dispose of the case by way of warnings and/or undertakings, rather than refer the case onto the Statutory Committee for disposal. Inevitably, most cases that fall into this category. The new legislation has established "referral criteria", and *only* those cases that meet the referral criteria, should be referred on to the Statutory Committee. By definition, these will be the more serious cases.

The Scrutiny Committee will therefore receive less serious cases, that do not pass the threshold for referral to the Statutory Committee, yet demand suitable censure or response on behalf of the Council of the Society. The purpose of this

part of the annual report is to inform the Council of the Society of the detail of such cases. There were eight cases considered, four of which resulted in **advice** about future conduct being given, whilst three cases resulted in a **formal warning**. One case resulted in a finding of **No Further Action**.
These cases are identified in the report at **appendix one** hereto.

Regulation 7(1)a(iii): "Reasons for non referral to Statutory Committee"

The Scrutiny Committee is obliged to explain, in this third part of the report, the reasons why the eight cases mentioned above did not pass the threshold for referral to the Statutory Committee. The purpose of this, is to satisfy the Council of the Society that the Scrutiny Committee is exercising its powers in an appropriate way.

For example, if the Council of the Society was concerned that the Committee was being too lenient in the way it disposed of any particular case or category of case, then the reasoning of the Committee should be readily available to be understood and explored.

This year, once case was dismissed. Of the seven other cases disposed of by way of advice or warning, four fell into the category of case which might be described as "dispensing error". The other cases involved criminal proceedings or misconduct of a relatively minor nature. In each case the Committee considered that the cases were serious enough by reference to the threshold criteria that the Registrar was correct in referring them to the Scrutiny Committee in the first place.

The Scrutiny Committee must not refer a fitness to practice allegation to the Statutory Committee unless it is satisfied that there is a real prospect that the Statutory Committee will make a finding that the registrant's fitness to practise is impaired. Each of the cases below had its own unique factual matrix, with mitigating factors in play. A short summary of the reasoning of the Committee in each case is set out below;

Appendix One;

Dispensing error cases;

1. **Registrant A & B**

This case involved both registrants making the same mistake, in connection with the dispensing of a syrup. The error involved the use Ml as opposed to Mg and would have been identified if the prescription had been checked as opposed to relying on the computer which had incorrect information contained on it.

In respect of the allegations, the Committee noted that the registrant had dispensed 100mls of Zantac (Ranitidine) Syrup (75mg/5ml) at a dose of 5mls three times a day to the patient's mother rather than Zantac (Ranitidine) Syrup at a dose of 5mgs three times a day as prescribed. The registrant had taken her instruction from records entered in the patient medication records on the pharmacy computer based on dosage information calculated on 22nd June 2011 by another pharmacist. These instructions were not in accordance with the legal prescription issued which was not referred to when dispensing. The registrant therefore had failed to assess the clinical appropriateness of the medication she was dispensing or check against the legal prescription. The Committee noted there was no dispute of the facts in that regard.

The Committee felt that the issues of particular concern were as follows:

i. There was no evidence of a check of the clinical appropriateness of the medication when dispensing;
ii. The registrant has admitted that she did not check the medication dispensed against the legal prescription;
iii. The patient's age should have been cause for heightened concern when dispensing this product;
iv. The person concerned should be content that the working environment has robust systems to allow for safe practise and should adhere to the systems in place.

The Committee accepted that the following factors were particularly relevant:

i. The Committee noted that there was no disputes of facts;
ii. There is no evidence of harm to the patient;
iii. The medication dispensed was not a high risk product;
iv. This was a one-off dispensing error on the part of the registrant;

2. Registrant C

This case involved the registrant making a mistake, in connection with the dispensing of a custard, for an infant. The error involved dispensing custard when in fact the prescription stated a syrup should be used, however it had occurred 88 times .

The Committee were of a view that the person concerned had practised in a way that was systemically unsafe by repeatedly failing to check that she was dispensing in accordance with a legal prescription and admitted to this in her letter.

In mitigation:

- The Committee took into account the fact that the actual product dispensed was the product that was intended to be prescribed. The change to the prescription first issued remains somewhat unexplained;
- The patient did not suffer any harm as a result of the dispensing errors;

- The person concerned had displayed a high level of insight in relation to the potential seriousness of the matters, has implemented appropriate measures and undergone training to prevent any recurrence;
- The person concerned had fully accepted the recommendations of the registrar in regard to the measure for disposal of the case;
- The person concerned had fully cooperated with the investigation and had made a full apology to the patient's mother;
- The Committee were of the view that there was a low likelihood of any recurrence of an incident of a similar nature.

3. Registrant D

In this case the Scrutiny Committee has found that the Registrant in error on a single occasion dispensed an out of date packet of Estraderm. The Committee carefully considered all of the evidence before it including that of the patients GP and that of the Department of Health, Social Services and Public Safety. The Committee noted in particular a letter, dated 10th June 2015 which advised that it would appear that the illness suffered by the patient cannot be attributed to the out of date patches. The Committee further recognised the insight shown by the Registrant in the circumstances and the fact that SOPs at her place of work have been amended to prevent a similar situation arising.

'Other' cases

4**. Registrant E**

This case involved the registrant omitting to disclose a police caution, which had been given when she was still a student, when completing forms.

The committee had regard to the following issues in reaching its decision in this case:

- The Scrutiny Committee considered the documentation presented to it and noted that there was no evidential dispute of the facts;
- That the registrant had already received a warning sanction from their previous employer while on work placement with the Trust;
- That the registrant had already signed undertakings, from the Registrar, to disclose to future employers their fitness to practise proceedings; outlining the understanding of the registrant of the gravity of the situation and subsequent proceedings;
- That the registrant had made a submission to the Scrutiny Committee, outlining her response in respect of the allegations and the Scrutiny Committee agreed that there was no deliberate attempt to mislead in the explanation of events surrounding the proven facts of the police caution;
- That the caution was received before the registrant was a pre-registration trainee, while under the governance framework of Queens

university Belfast therefore the Committee had no powers at that time to progress proceedings;

- That the proceedings subsequently issued were when the Pharmaceutical Society of northern Ireland took over fitness to practise responsibilities when the registrant transferred from Queens university Belfast to become a pre- registration trainee;
- That any sanction less that a warning would be inappropriate;
- That the registrant would not be referred to a Statutory Committee hearing because she was not a registered pharmacist at the time of the incident in question as the explanation of facts in the personal communication to the Committee were accepted by the Committee;

In mitigation the Committee noted that:

- The person concerned had fully admitted that her conduct was inappropriate, that it fell below the standard expected of a professional person and had expressed great remorse for her actions;

5. Registrant F

This case involved the registrant in inappropriate text messaging with a patient, including messages with a sexual content.

The Committee had regard to the following issues in reaching its decision in this case:

- The Scrutiny Committee considered the documentation presented to it and noted that there was no evidential dispute of the facts;
- The Committee were concerned to note that the person concerned was the responsible pharmacist on duty when some of the inappropriate text messages documented within the papers, were sent to the patient;
- The Committee were further concerned that it was the patient who reminded the person concerned of their professional relationship during the course of the text message exchange. The Committee commented that the behaviour of the registrant fell below the standards and supplementary guidance published by the Pharmaceutical Society, in that the conduct was of an inappropriate nature due to the imbalance of power that exists between a healthcare professional and their patient;
- The Committee noted that the person concerned had encouraged the patient to delete the messages sent which highlighted the fact that he knew that the exchange was inappropriate;
- The Committee were concerned to note that this inappropriate exchange of text messages was continued for a period of 2 months.

In mitigation the Committee noted that:

- The person concerned had fully admitted that his conduct was inappropriate, that it fell below the standard expected of a professional person and had expressed remorse for his actions;
- The person concerned has indicated, in the written representations received on his behalf from his solicitors, an intention to complete a course entitled 'Introduction to professional boundaries' in May 2015.

6. Registrant G

This case involved the registrant being convicted of driving with excess alcohol.

It was alleged that there was evidence of behaviour on the part of the person concerned which is likely to undermine public confidence in the profession generally, if not challenged by the regulatory body. The allegation was admitted. The Committee was of the opinion that this was an appropriate case to exercise its power to issue a warning. The Committee considered that the public perception of drink driving, was that it was socially unacceptable and should be considered as a serious matter in every case and particularly so, when it involved a healthcare professional who ascribed to a level and standard of behaviour befitting the profession to which they belong.

In this case the Scrutiny Committee has found that the Registrant promptly acknowledged the fact of her conviction and showed insight and application in dealing with the situation. The Committee acknowledges the commitment of the Registrant to addressing the situation.

The Committee wish to make it clear that if any of these factors had been absent or if there had been any aggravating factors to the facts of the offence, it would have been unable to conclude that the case was capable of being disposed of without reference to the Statutory Committee. The published GMC guidance notes as follows:

"Examples of convictions and cautions that have resulted in a warning include one off drink driving offences where we are satisfied that there are no underlying health concerns ".

The Committee concluded that this case fell into that description and there were no compelling reasons to treat the matter in a different way.

Conclusion

I trust that this report will again provide a useful insight into the work of the Scrutiny Committee in the past year, and reassurance to the Society that these important issues are being addressed in accordance with the new legislation, and in a satisfactory and proportionate way. As Chair, I am again delighted that my colleagues and I have dealt with the cases in a timely and professional way and to a high standard.

Accordingly, I commend the 2015 report to you.

As Chair of the Scrutiny Committee I can report that the Committee members have found the work they have been tasked with, to be challenging, varied and interesting. We have benefitted greatly from the training and assistance provided by the Society, together with the dedicated and professional preparatory work carried out by the administration office, to who we owe a debt of gratitude.

John Gibbons
(Chair of the Scrutiny Committee)
31 May 2016

Appendix two

Threshold Criteria for referral to Scrutiny Committee

Cases are not to be referred to the Scrutiny Committee unless one of the following statements is true:

Principle 1: Make the safety and welfare of patients your prime concern

- There is evidence that the registered person's conduct or performance caused moderate or severe harm or death, which could and should have been avoided.

- There is evidence that the registered person deliberately attempted to cause harm to patients and the public or others.

- There is evidence that the registered person was reckless with the safety and well-being of others.

Principle 2: Respect and protect confidential information

- There is evidence that the registered person failed to respect the confidentiality of information or misused confidential information acquired in the course of professional practice to an extent likely to undermine public confidence in the profession if not challenged by the regulatory body.

Principle 3: Show respect for others

- There is evidence that the registered person failed to respect the human rights of patients, or demonstrated in their behaviour attitudes which are incompatible with registration as a pharmacy professional.

- There is evidence that the registered person failed to maintain appropriate professional boundaries in their relationship with patients and/or others.

Principle 4: Exercise professional judgment in the interests of patients and public

- There is evidence that the registered person put their own interests, or those of a third party, before those of their patients.

- There is evidence that the registered person culpably failed to act when necessary in order to protect the safety of patients.

Principle 5: Encourage patients (and/or their carers as appropriate) to participate in decisions about their care

- There is evidence that the registered person damaged or put at significant risk the best interests of patients by failing to communicate appropriately with patients or others.

Principle 6: Maintain and develop professional knowledge and competence

- There is evidence that the registered person practised outside of their current competence.

- There is evidence that the registered person failed to maintain their knowledge and skills in a field relevant to their practice.

- There is evidence of a course of conduct, which is likely to undermine public confidence in the profession generally or put patient safety at risk, if not challenged by the regulatory body.

- There is evidence of adverse physical or mental health which impairs the registered person's ability to practice safely or effectively.

Principle 7: Act with honesty and integrity

- There is evidence that the registered person behaved dishonestly.

- There is evidence of behaviour on the part of the registered person which is likely to undermine public confidence in the profession generally, if not challenged by the regulatory body.

Principle 8: Provide a high standard of practice and care at all times

- There is evidence that the registered person has practised in a way that was systematically unsafe, or, has allowed or encouraged others to do so, where he or she has responsibilities for ensuring a safe system of working.

If the Registrar is in doubt as to whether the above criteria have been met, he shall refer the case to the Scrutiny Committee.