Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting

8 October 2020

Nursing and Midwifery Council, Virtual Meeting

Name of registrant:	Mrs Lali Jose Valiyaparambil
NMC PIN:	02I0134O
Part(s) of the register:	Registered Nurse – sub part 1 Adult Nursing (3 September 2002)
Area of Registered Address:	Birmingham
Type of Case:	Lack of Competence
Panel Members:	Barbara Stuart (Chair, Lay member) Allison Hume (Registrant member) David Boyd (Lay member)
Legal Assessor:	Michael Bell
Panel Secretary:	Anjeli Shah
Facts proved:	**1 b)**
Facts proved by admission:	**2, 3, 4, 5, 6, 7**
Facts not proved:	**1 a)**
Fitness to practise:	**Impaired**
Sanction:	**Conditions of Practice Order for 18 months**
Interim Order:	**Interim Conditions of Practice Order for 18 months**

Decision on Service of Notice of Meeting

The panel was informed that notice of this meeting was sent to Mrs Valiyaparambil on 27 August 2020 to her email address on the register. Notice of this meeting was also sent to Mrs Valiyaparambil's representative by email on 27 August 2020.

The notice of meeting informed Mrs Valiyaparambil that her case would be considered at a meeting on or after 28 September 2020.

The panel accepted the advice of the legal assessor.

Rules 11A and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (as amended) ("the Rules") states:

> ***'11A.****(1) Where a meeting is to be held in accordance with rule 10(3), the Fitness to Practise Committee shall send notice of the meeting to the registrant no later than 28 days before the date the meeting is to be held.*
>
> ***34****.(1) Any notice of hearing required to be served upon the registrant shall be delivered by sending it by*
> *(a) a postal service or other delivery service in which delivery or receipt is recorded to, or by leaving it at, the registrant's address in the register; or*
> *(b) a postal service or other delivery service in which delivery or receipt is recorded to, or by leaving it at, where this differs from, and it appears to the Council more likely to reach the registrant at, the registrant's last known address; or*
> *(c) electronic mail to an electronic mail address that the registrant has notified to the Council as an address for communications*

The panel noted that under the recent amendments made to the Rules during the COVID-19 emergency period, notice of a hearing or meeting can be sent to an email

address held for a registrant on the NMC's register, or an email address which the registrant has informed the NMC is suitable for communication.

The panel considered that notice of this meeting was sent to an email address held for Mrs Valiyaparambil on the NMC register, and that this was sent at least 28 days in advance of the date she was informed the meeting would be considered on or after (28 September 2020). The panel was satisfied that notice of this meeting had been served in accordance with Rules 11A and 34.

The panel noted an email from Mrs Valiyaparambil's representative dated 4 September 2020, which set out Mrs Valiyaparambil's responses to the charges. Within that email, reference was made to a further statement and the representative indicated that he would be returning a Case Management Form ("CMF") during the week commencing 14 September 2020. The panel noted that a CMF did not appear in the documentation before it. An email had been sent to Mrs Valiyaparambil's representative on 21 September 2020, by an NMC case officer, indicating that the CMF had not been received, that Mrs Valiyaparambil's case would be considered on or after 28 September 2020, and that if there was any further information to provide, that this should be sent no later than 25 September 2020. There did not appear to be any further information provided from Mrs Valiyaparambil or her representative since the email sent on 4 September 2020.

The panel had concerns about proceeding with the meeting, in light of:

- The indication that CMF would be sent but this having not been received;
- The email of 4 September 2020 indicating that there was a further statement written by Mrs Valiyaparambil but this not appearing before the panel; and
- The fact that within the NMC bundle, there was email correspondence between Mrs Valiyaparambil and UNISON. Such correspondence would be regarded as confidential and would not usually be put before a panel.

Enquiries were made by an NMC case officer with Mrs Valiyaparambil's representative to address these points. Mrs Valiyaparambil's representative responded to state that the email correspondence between Mrs Valiyaparambil and UNISON should not appear before the panel, and that these emails were sent to the NMC merely to provide an update in relation to Mrs Valiyaparambil's situation. Mrs Valiyaparambil's representative also sent an email to the NMC enclosing a statement from Mrs Valiyaparambil. The representative stated that this statement could be shown to the panel, and that he believed the statement may have been "refined subsequently, but this is the only version currently available". Mrs Valiyaparambil's representative also confirmed that they had no objections to the sanction bid being put forward by the NMC in relation to this case.

The panel noted that the NMC has indicated that they were content for the statement written by Mrs Valiyaparambil to be placed before it, and that it did not alter the NMC's position with regard to the statement of case and the sanction bid. The panel noted that the contents of the statement written by Mrs Valiyaparambil appeared consistent with her admissions and denials of the charges, as set out in the email from her representative dated 4 September 2020.

In light of the information obtained as a result of enquiries made with Mrs Valiyaparambil's representative, and with the NMC, the panel considered that it would be appropriate for it to proceed to consider this meeting. The panel considered that appropriate steps had been taken for it to explore its concerns, and following the enquiries made with Mrs Valiyaparambil's representative and the NMC, it noted that both parties appeared to be content for the case to be considered, on the basis of the information being put forward. The panel considered that it now had sufficient information for it to properly and fairly consider Mrs Valiyaparambil's case today.

The panel therefore proceeded to consider Mrs Valiyaparambil's case at a meeting.

Details of charge:

That you a registered nurse, failed to demonstrate the standards of knowledge, skill and experience required to practise safely as Band 6 nurse between 6 April 2017 and 13 August 2018, and as a Band 5 nurse between 13 August 2018 and 8 February 2019 in that you:

1. *On 6 April 2017:*

    a. *did not adequately support or supervise a junior colleague in providing care to patients on inotropes;* **(not proved)**

    b. *did not wake a colleague who was asleep on shift;* **(proved)**

2. *On 19 December 2017 incorrectly administered 2mg of haloperidol intravenously to a patient.* **(proved by admission)**

3. *On 20 January 2018 failed to document medication that had been administered to a patient.* **(proved by admission)**

While subject to a stage 1 formal action plan:

4. *On 31 July 2018 incorrectly escalated a same sex breach on the High Dependency Unit.* **(proved by admission)**

5. *On 31 July 2018 you were late for a fire drill.* **(proved by admission)**

While subject to a stage 2 formal action plan:

6. *On 24 October 2018 incorrectly documented medication for a patient who had been discharged.* **(proved by admission)**

7. *On 20 December 2018 incorrectly administered 10mg of Oxylan to a patient.* **(proved by admission)**

And, in light of the above, your fitness to practise is impaired by reason of your lack of competence.

Background

Mrs Valiyaparambil was employed by the Royal Orthopaedic Hospital NHS Foundation Trust ("the Trust)" as a Band 6 Senior Staff Nurse in the High Dependency Unit ("the Unit") from 26 April 2002 until 13 August 2018. From 13 August 2018 until 8 February 2019 Mrs Valiyaparambil was employed as a Band 5 Staff Nurse in the Unit. On 8 February 2019 Mrs Valiyaparambil resigned from the Trust.

In 2017 Mrs Valiyaparambil was the Clinical Site Coordinator and the nurse in charge of the Unit.

Ms 1, Mrs Valiyaparambil's line manager, obtained information from Ms 2, a junior qualified nurse, that Mrs Valiyaparambil allegedly did not provide Ms 2 with support in caring for two patients on inotropes. These medications are used to raise patients' blood pressure and are said to be challenging for nurses. This incident was alleged to have occurred on 6 April 2017.

On the same date, Ms 3, a senior nurse, was said to have fallen asleep at the nurses station for two hours with her head on the desk, when she was supposed to be providing support to Ms 2, a junior nurse. It is alleged that Mrs Valiyaparambil did not wake Ms 3 up. In a reflective piece, Mrs Valiyaparambil said she had seen Ms 3's head on the desk on one occasion, but she did not realise that Ms 3 was sleeping.

Mrs Valiyaparambil was placed on an action plan by Ms 1, with the first informal capability meeting taking place on 24 May 2017. The aim of the action plan was to assess Mrs Valiyaparambil's delegation skills, for her to read the NMC Code of Conduct, for her to attend an assertiveness course and for her to work alongside the Clinical Site Coordinator. Mrs Valiyaparambil received positive feedback and completed the action plan on 26 September 2017. Mrs Valiyaparambil was then allowed to resume

normal activities. A second informal capability meeting was held on 3 October 2017, with a plan for Mrs Valiyaparambil to return to her role as the Clinical Site Coordinator.

It is alleged that on 19 December 2017 Mrs Valiyaparambil incorrectly administered 2mg haloperidol intravenously to a patient with Parkinson's disease. Mrs Valiyaparambil has admitted this charge, and at the time, she wrote a reflective piece stating that she would be more vigilant in the future.

It is alleged that on 20 January 2018 Mrs Valiyaparambil did not sign for medication that she had administered. Mrs Valiyaparambil has admitted this charge.

On 17 April 2018 a Stage 1 formal meeting was held with Mrs Valiyaparambil, focused on effective prioritisation and developing the skills to take charge in the ward. This stage 1 formal action plan was due for completion in August 2018.

It is alleged that on 31 July 2018 Mrs Valiyaparambil incorrectly escalated a same sex breach on the Unit. Mrs Valiyaparambil has admitted this charge. The same sex breach protocol is used for situations where patients of mixed gender are being cared for in the same bay and one patient requires discharge in certain timeframes. In this situation, the patients were in separate side rooms, and not in the same bay. When Mrs Valiyaparambil was asked why she escalated a same sex breach, she said "it would make it quicker and easier to get the patient off the ward", which was an incorrect use of the same sex breach protocol.

A second stage 1 formal review meeting was held with Mrs Valiyaparambil on 1 August 2018.

It is alleged that on 9 August 2018 Mrs Valiyaparambil was late for a fire drill. Mrs Valiyaparambil has admitted this allegation. On this date, Mrs Valiyaparambil was holding the Clinical Site Coordinator beep when the alarm went off, and it would have been her role to attend at the meeting site. Mrs Valiyaparambil asked a Band 5 nurse to

attend, and she herself attended 10 minutes late. In a reflective piece, Mrs Valiyaparambil explained that she had been stocking a box and suffered a cramp in her leg.

At a stage 2 meeting on 9 August 2018 Ms 1 escalated matters to a stage 3 level. It was decided that Mrs Valiyaparambil could not be in a positon of responsibility on the Unit, and she was demoted to a Band 5 nurse. Mrs Valiyaparambil was provided with another action plan, to be completed over the course of 24 months, in order to recognise her limits, enhance her skills and seek advice when appropriate.

It is alleged that on 24 October 2018 Mrs Valiyaparambil documented the administration of intravenous paracetamol to a patient, when that patient was no longer on the Unit. Mrs Valiyaparambil has admitted this charge. It was assumed that a patient was administered intravenous paracetamol, but not the one who was discharged from the Unit. Mrs Valiyaparambil wrote a reflective piece and stated that she would check in the future.

On 18 November 2018 a stage 2 formal review took place. It was decided that Mrs Valiyaparambil should reduce her bank shifts to one per week.

On 20 December 2018 it is alleged that Mrs Valiyaparambil incorrectly administered 10mg oxylan instead of the prescribed 10mg morphine sulphate to a patient. Mrs Valiyaparambil wrote a reflective piece, claiming confusion in the prescription.

A stage 2 formal review meeting was held with Mrs Valiyaparambil on 10 January 2018 and she was offered a demotion to a Band 2 Healthcare Assistant. Mrs Valiyaparambil chose to resign from the Trust, with effect from 8 February 2019.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case.

The panel accepted the advice of the legal assessor.

The panel is aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that the facts will be proved if the panel is satisfied that it is more likely than not that the incidents occurred as alleged.

The panel noted that in an email from Mrs Valiyaparambil's representative dated 4 September 2020, Mrs Valiyaparambil admitted the following charges:

That you a registered nurse, failed to demonstrate the standards of knowledge, skill and experience required to practise safely as Band 6 nurse between 6 April 2017 and 13 August 2018, and as a Band 5 nurse between 13 August 2018 and 8 February 2019 in that you:

2. *On 19 December 2017 incorrectly administered 2mg of haloperidol intravenously to a patient.*

3. *On 20 January 2018 failed to document medication that had been administered to a patient.*

While subject to a stage 1 formal action plan:

4. *On 31 July 2018 incorrectly escalated a same sex breach on the High Dependency Unit.*

5. *On 31 July 2018 you were late for a fire drill.*

While subject to a stage 2 formal action plan:

6. *On 24 October 2018 incorrectly documented medication for a patient who had been discharged.*

7. *On 20 December 2018 incorrectly administered 10mg of Oxylan to a patient.*

The panel therefore found these charges proved by way of Mrs Valiyaparambil's admissions.

The panel went on to consider the remaining charges and made the following findings:

Charge 1 a):

That you a registered nurse, failed to demonstrate the standards of knowledge, skill and experience required to practise safely as Band 6 nurse between 6 April 2017 and 13 August 2018, and as a Band 5 nurse between 13 August 2018 and 8 February 2019 in that you:

1. *On 6 April 2017:*

    a. *did not adequately support or supervise a junior colleague in providing care to patients on inotropes;*

This charge is found not proved.

In reaching this decision, the panel took into account the witness statement of Ms 1 dated 25 September 2019 and the witness statement of Ms 2 dated 27 September 2019.

The panel noted that on the date of the incident, Mrs Valiyaparambil was the nurse in charge of the shift. Ms 3, another nurse on shift, was delegated the task of providing support to Ms 2, a junior nurse. The panel noted the evidence before it indicating that Ms 2 was not provided adequate support or supervision in providing care to patients on inotropes.

The panel noted that as the nurse in charge, Mrs Valiyaparambil would have had a duty to provide support to the other nurses on the Unit. However, it also noted that as the nurse in charge, she had the ability to delegate tasks, and it considered that on this occasion, the evidence before it demonstrated it that she had delegated the support and supervision of a junior member of staff (Ms 2) to another registered nurse (Ms 3). The panel considered that Ms 3, as a registered nurse, would have then had a duty to provide adequate support and supervision to the junior member of staff, in accordance with her professional responsibilities under the NMC Code of Conduct. The panel did not consider there to be evidence to suggest that Mrs Valiyaparambil did not adequately support or supervise a junior colleague, when this responsibility would have fallen upon Ms 3.

The panel therefore determined that, on the balance of probabilities, this charge is not proved.

Charge 1 b):

That you a registered nurse, failed to demonstrate the standards of knowledge, skill and experience required to practise safely as Band 6 nurse between 6 April 2017 and 13 August 2018, and as a Band 5 nurse between 13 August 2018 and 8 February 2019 in that you:

1. On 6 April 2017:

b. did not wake a colleague who was asleep on shift;

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Ms 1 dated 25 September 2019, the witness statement of Ms 2 dated 27 September 2019, notes of an investigation interview with a staff nurse dated 16 June 2017, a reflective piece written by Mrs Valiyaparambil in relation to the incident on 6 April 2017 and the email from Mrs Valiyaparambil's representative dated 4 September 2020.

The panel had regard to the witness statements of Ms 1 and Ms 2 and the investigation interview with a staff nurse on 16 June 2017. This evidence all suggested that on 6 April 2017, Ms 3 had her head on the desk at the nurses station for approximately two hours. The panel noted that Ms 1 and Ms 2 were of the view that Ms 3 was asleep during this time. It considered that there was sufficient evidence to suggest that Ms 3 was asleep.

The panel had regard to Mrs Valiyaparambil's reflective piece, written near to the time of the incident, where she stated that she recalled one occasion where Ms 3 had her head down on the desk, but she "did not realise she had nodded off at this point". Mrs Valiyaparambil confirmed this position in the email from her representative dated 4 September 2020, where she said that Ms 3 was laying with her head on the table and her phone in her lap, but Mrs Valiyaparambil did not think Ms 3 was sleeping.

The panel considered that there was sufficient evidence to suggest that Ms 3 was asleep during the shift on 6 April 2017. The panel considered the information from Mrs Valiyaparambil, that she did not think Ms 3 was asleep. There was no evidence before the panel to suggest Mrs Valiyaparambil had tried to wake Ms 3, and it considered that

this would been unlikely if she did not think Ms 3 was asleep. On the basis of all of this evidence, the panel considered that it was more likely than not that Mrs Valiyaparambil did not wake Ms 3.

The panel therefore determined that, on the balance of probabilities, this charge is found proved.

Lack of competence and impairment

Having made its findings on the facts, the panel went on to consider whether the facts found proved amount to a lack of competence, and if so, whether Mrs Valiyaparambil's fitness to practise currently impaired as a result of that lack of competence. The panel adopted a two-stage process.

The panel accepted the advice of the legal assessor.

Decision on lack of competence

When determining whether the facts found proved amount to a lack of competence the panel had regard to the terms of the *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) ("the Code").

The panel, in reaching its decision, has had regard to the protection of the public and the wider public interest and accepted that there is no burden or standard of proof at this stage and exercised its own professional judgement.

The NMC has defined a lack of competence as:

> A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.

The panel considered that the following sections of the Code were engaged in this case:

> **10 Keep clear and accurate records relevant to your practice**

…

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

…

10.3 complete records accurately…taking immediate and appropriate action if you become aware that someone has not kept to these requirements

…

18 …administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

…

20.1 keep to and uphold the standards and values set out in the Code

…

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people"

In considering whether the facts found proved amount to a lack of competence, the panel concluded that you breached the aforementioned sections of the Code, which are the standards by which every registered nurse is measured. The panel bore in mind, when reaching its decision, that Mrs Valiyaparambil should be judged by the standards of the reasonable average band 6 registered nurse in relation to the incidents which occurred between 6 April 2017 and 13 August 2018, and the standards of a band 5

registered nurse, in relation to the incidents which occurred between 13 August 2018 and 8 February 2019, and not by any higher or more demanding standard.

The panel noted that the facts found proved involved a number of incidents over a period of time, and these involved fundamental aspects of nursing practice. A number of Mrs Valiyaparambil's failings concerned poor practice with regards to medicines administration and management, as well as record keeping, providing adequate leadership to other staff and complying with protocols.. The panel considered that the standards expected of a registered nurse in these particular areas of practice were universal. The panel therefore considered that such standards would have been applicable when Mrs Valiyaparambil was working as a band 6 nurse, as well as when she was working as a band 5 nurse. Taking this all into account, the panel considered that Mrs Valiyaparambil's practice was below the standard that one would expect of the average registered nurse acting in the roles that she was at the time of these incidents. The panel considered that on these occasions, Mrs Valiyaparambil acted in a way in which no responsible practitioner in her particular role would have acted. In all the circumstances, and taking all of the facts found proved collectively, the panel determined that Mrs Valiyaparambil's performance demonstrated a lack of competence.

Decision on impairment

The panel next went on to decide if as a result of this lack of competence Mrs Valiyaparambil's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. Nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the panel considered the judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) in reaching its decision. In paragraph 74 she said:

> "In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."

Mrs Justice Cox went on to say in Paragraph 76:

> "I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my

view the test would be equally applicable to other practitioners governed by different regulatory schemes.

> Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
>
> a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
>
> b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
>
> c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
>
> d. ..."

The panel finds that limbs a, b and c, as set out above, were engaged by Mrs Valiyaparambil's past actions and omissions. The panel considered that Mrs Valiyaparambil's failings involved fundamental areas of nursing practice. The panel considered that there were incidents where Mrs Valiyaparambil's failed to administer medication as prescribed, where she failed to administer medication to the correct patient and where she failed to record the administration of medication. The panel considered that these failings put patients at risk of harm. The panel considered that registered nurses would be expected by members of the public to provide safe and effective care, and to fulfil such fundamental aspects of nursing. The panel considered Mrs Valiyaparambil, in failing to provide such fundamental aspects of nursing care, brought the profession into disrepute. The panel also considered that Mrs Valiyaparambil breached fundamental tenets of the profession, as set out in the Code.

The panel went on to consider whether Mrs Valiyaparambil was liable to act in a way so as to put patients at risk of harm, to bring the profession into disrepute and to breach fundamental tenets of the profession in the future. In doing so, the panel assessed whether there was evidence of insight and remediation.

In relation to insight, the panel had regard to Mrs Valiyaparambil's reflective piece. The panel considered that Mrs Valiyaparambil had demonstrated developing insight. In making this assessment, the panel considered that Mrs Valiyaparambil had recognised that she had made failings, detailed what she had learnt from the incidents and she had demonstrated how she was seeking to address those failings, in order to develop her nursing practice in the future. In particular, it noted the following:

> "*…I will be attending medicine competency course which will also increase my knowledge and skills. I have learnt how to like this positively and released that it had improved my skills and outlook as a nurse and I can say that I am well aware and prepared to face events like this in the future, with different environment and work place I will be able to focus and prove myself and become the best version of me as a nurse (sic).*"

Whilst Mrs Valiyaparambil had demonstrated developing insight, the panel did not consider that this process was complete. It considered that Mrs Valiyaparambil had not sufficiently addressed the impact of her acts and omissions on patients, who could have faced serious harm as a result of her failings, as well as the impact upon her colleagues and on the reputation of the nursing profession.

In relation to remediation, the panel noted that Mrs Valiyaparambil had attended a workshop in Practical Competencies in Medicines Administration, and the panel had a certificate of completion dated 23 July 2019 before it. Whilst the panel considered that this demonstrated Mrs Valiyaparambil's attempts to remediate in relation to a particular area of concern with her clinical practice, it noted that there was no other evidence of

remediation before it. There was no information, by way of any testimonials or other evidence, to suggest that Mrs Valiyaparambil had been working safely in a clinical environment since the incidents had occurred in this case.

The panel therefore considered that whilst Mrs Valiyaparambil's insight was developing and she had begun to address the concerns with her practice, this process was not complete. In light of the lack of evidence to suggest that the concerns had been fully remediated, and that Mrs Valiyaparambil had gained sufficient insight into her failings, the panel considered that a risk of repetition remains, and that patients would be placed at risk of harm if Mrs Valiyaparambil were able to practise without restriction. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and wellbeing of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession. The panel considered that the charges found proved in this case involved failings in fundamental aspects of nursing practice. These involved areas of practice in which patients and members of the public would expect registered nurses to be able to provide safe and effective care to the required standard. The panel considered that confidence in the nursing profession and in the NMC as a regulator would be undermined, and that standards of conduct and performance would not be upheld, if a finding of impairment were not made in the circumstances. The panel therefore determined that a finding of impairment is also necessary on public interest grounds.

Having regard to all of the above, the panel was satisfied that Mrs Valiyaparambil's fitness to practise is currently impaired.

Determination on sanction:

The panel has considered this case carefully and has decided to make a conditions of practice order for a period of 18 months. The effect of this order is that Mrs Valiyaparambil's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

In reaching this decision, the panel has had regard to all the documentary evidence in this case. The panel accepted the advice of the legal assessor. The panel bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance ("SG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel noted that within the NMC's statement of case, it put forward a sanction bid for an 18 month conditions of practice order. The panel noted that such a sanction was not contested by Mrs Valiyaparambil or her representative.

The panel first considered what it deemed to be the aggravating and mitigating factors in this case.

<u>Aggravating factors:</u>

- The panel was unable to identify any aggravating factors.

<u>Mitigating factors:</u>

- Mrs Valiyaparambil's admissions to a number of the charges, including at an early stage and at a local level.

The panel then went onto consider what action, if any, to take in this case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the outstanding risks identified with Mrs Valiyaparambil's clinical practice. Taking no action would not restrict Mrs Valiyaparambil's practice. The panel decided that taking no further action would not protect the public and it would not satisfy the wider public interest.

The panel next considered whether a caution order would be appropriate in the circumstances. The panel took into account the SG, which states that a caution order may be appropriate where:

> "…the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise Committee wants to mark that the behaviour was unacceptable and must not happen again."

The panel considered that given the outstanding risks identified with Mrs Valiyaparambil's clinical practice, this case was not at the lower end of the spectrum of impaired fitness to practise. Imposing a caution order would also not restrict Mrs Valiyaparambil's practice. The panel decided that imposing a caution order would not protect the public and it would not satisfy the wider public interest.

The panel next considered whether to impose a conditions of practice order. The panel was mindful that any conditions imposed must be measurable, practicable and workable. The panel had regard to Mrs Valiyaparambil's engagement with these proceedings, and the steps she had taken to begin to address her failings, which included reflecting on her failings and undertaking training in medicines administration. The panel considered that Mrs Valiyaparambil had demonstrated a willingness to respond positively to retraining, and that she would be willing and able to comply with a conditions of practice order. The panel noted that Mrs Valiyaparambil's failings involved specific areas of Mrs Valiyaparambil's clinical practice, which it considered are remediable. It considered that it would be possible to formulate measurable, practicable

and workable conditions to specifically address these clinical areas of concern, and which would suitably protect the public and satisfy the public interest.

The panel considered whether to impose a suspension order. The panel had regard to Mrs Valiyaparambil's engagement with these proceedings, her demonstration of developing insight and the steps she had taken to begin to address the clinical concerns. The panel considered that the concerns in this case are remediable and that Mrs Valiyaparambil had demonstrated a willingness to remediate the issues with her clinical practice. The panel also considered that Mrs Valiyaparambil's failings were not so serious as to require her temporary removal from the register. The panel therefore determined that a suspension order would be disproportionate.

The panel is satisfied that a conditions of practice order is appropriate and proportionate in the circumstances of this case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

<u>For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.</u>

1. At any time that you are administering medication, you must do so under the supervision of another registered nurse, until such a time as you are deemed

competent to do so without supervision by your workplace line manager, mentor or supervisor (or their nominated deputy).

2. You must work with your workplace line manager, mentor or supervisor (or their nominated deputy) to create a personal development plan ("PDP"). Your PDP must address the concerns about your medicines administration and management. You must:
    a) Send your case officer a copy of your PDP prior to the review hearing;
    b) Meet with your workplace line manager, mentor or supervisor (or their nominated deputy) at least monthly to discuss your progress towards achieving the aims set out in your PDP;
    c) Send your case officer a report from your workplace line manager, mentor or supervisor (or their nominated deputy) prior to the review hearing, setting out your progress towards achieving the aims set out in your PDP.

3. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment;
    b) Giving your case officer your employer's contact details.

4. You must keep us informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study;
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

5. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for;
    b) Any agency you apply to or are registered with for work;
    c) Any employers you apply to for work (at the time of application);

d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study;
e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

6. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in;
    b) Any investigation started against you;
    c) Any disciplinary proceedings taken against you.

7. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer;
    b) Any educational establishment;
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The panel determined to impose this conditions of practice order for a period of 18 months. The panel considered that this would provide Mrs Valiyaparambil with sufficient time to obtain employment subject to these conditions, to work towards addressing the clinical concerns as set out within the conditions of practice order, and to address the recommendations set out below, before evidencing these before a future reviewing panel.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mrs Valiyaparambil has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order with another order.

Any future panel reviewing this case may be assisted by evidence of the following:

- A reflective piece written by Mrs Valiyaparambil focusing on the potential impact of the charges (including those admitted and those found proved by the panel) on patients, colleagues and on the reputation of the nursing profession;
- Testimonials from any work Mrs Valiyaparambil has undertaken, whether paid or unpaid; and
- Any training Mrs Valiyaparambil has undertaken, as well as any other steps she has taken to keep her clinical skills and knowledge up to date.

Determination on Interim Order

Under Article 31 of the Nursing and Midwifery Order 2001 ("the Order"), the panel considered whether an interim order should be imposed in this case. A panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, and/or is otherwise in the public interest, and/or is in the registrant's own interests.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim conditions of practice order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. To do otherwise would be incompatible with its earlier findings.

The conditions for the interim order will be the same as those detailed in the substantive order.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by the conditions of practice/ order 28 days after Mrs Valiyaparambil is sent the decision of this hearing in writing.

That concludes this determination.