Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
23 – 24 August 2023

Virtual Meeting

Name of Registrant:	**Valerie Jean Howard**
NMC PIN	09L0384E
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nursing – 27 October 2010
Relevant Location:	Leicester
Type of case:	Lack of competence
Panel members:	John Vellacott (Chair, Lay member) Terry Shipperley (Registrant member) Jocelyn Griffith (Lay member)
Legal Assessor:	Nigel Pascoe KC
Hearings Coordinator:	Tyrena Agyemang
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Ms Howard's registered email address by secure delivery on 18 July 2023.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Ms Howard's registered postal address on 19 July 2023. It was signed for against the printed name of '*HOWARD'*.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, the time, date and the fact that this meeting was being heard virtually.

In the light of all of the information available, the panel was satisfied that Ms Howard has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, between 18 February 2016 and 22 March 2019 failed to demonstrate the standards of knowledge, skills and judgement required to practise without supervision as a band 5 nurse in that you:

1. On or around 19 February 2016 administered medication, namely Lorazepam, to the wrong patient. – **Found proved**

2. On or around 28/29 August 2016 failed to attend the patient's bedside when acting as a second checker for intravenous medication, namely Flucloxacillin. – **Found proved**

3. On or around 1 September 2016 administered intravenous fluids/medication which was not prescribed. – **Found proved**

4. On 1 April 2017:

    a) Administered the incorrect medication to Patient C, namely 20mg of immediate release Oxycodone instead of the prescribed 20mg prolonged release Oxycodone; – **Found proved**

    b) Made the medication error in 4(a) above whilst you were subject to a first written warning for capability. – **Found proved**

5. On 21 March 2019 administered an incorrect dose of medication, namely 7mg of Warfarin to Patient A. – **Found proved**

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

Background

The charges arose whilst Ms Howard was employed as a band 5 registered nurse by University Hospitals of Leicester NHS Trust (the Trust) at Leicester Royal Infirmary ('the Hospital').

It was alleged that between February and September 2016, Ms Howard was involved in three medication administration incidents. The first of these (February 2016) concerned Ms Howard administering medications to the incorrect patient, following a verbal request from a doctor. The second matter (28 / 29 August 2016) related to Ms Howard's failure to act as a second checker for intravenous medication. The third incident (on or around 1 September 2016) concerned Ms Howard's failure to check a prescription for insulin.

The above matters culminated in Ms Howard receiving a written warning on 29 September 2016, following an Improving Performance (Capability) hearing on 26 September 2016.

Witness 1 confirms that, while they were not a direct witness to these medication errors, they were involved with the hearing and personally signed the written warning. Witness 1 alleges that based on the information contained in the written warning, Ms Howard admitted the three 2016 medication errors at the hearing on 26 September 2016.

On 1 April 2017, Ms Howard administered the incorrect preparation of a controlled drug to Patient C. The patient was prescribed 20 mg prolonged release Oxycodone; however, Ms Howard administered 20 mg immediate release Oxycodone. Witness 1 was assigned to investigate this matter.

It was alleged that as a result of the error occurring within the twelve months operational period of Ms Howard's written warning, *'further management'* was required. Ms Howard was placed on an action plan in June 2016. It was further alleged by Witness 1 that Ms Howard did not appear to be doing everything she could to complete the action plan. The action plan was later completed and Ms Howard was signed off on 25 January 2018.

On 21 March 2019, Ms Howard administered 7 mg Warfarin to Patient A. However, Patient A was prescribed 2 mg Warfarin. Ms Howard made two entries in Patient A's records relating to the administration of Warfarin. The first indicated that Ms Howard had administered 7 mg and the second entry suggested that she had administered 2 mg.

Witness 4 was on duty with Ms Howard on 21 March 2019. Witness 4 was advised that there was a potential issue concerning medication administration to Patient A. Ms Howard stated that she had made a mistake on Patient A's drug chart but Witness 4 remained unconvinced about Ms Howard's explanation. When Witness 4 spoke to Ms Howard directly about the matter, she maintained that she had signed the wrong patient's chart and said that she had only administered 2 mg of Warfarin to Patient A.

On 22 March 2019, Witness 4 decided to investigate the incident further because they thought that it was a strange mistake that Ms Howard had made. Witness 4 thought that the difference between 2 mg and 7 mg of Warfarin is '*a big difference in dosage'*.

Witness 4 investigated the electronic patient medication administration record ('EPMA'). It was alleged that Ms Howard initially did not comment on the EPMA charts, but eventually

stated that she *'probably mistakenly gave the higher dose'*. Witness 4 escalated the matter to a matron.

Witness 4 recalled that Patient A was, '*visibly very upset and anxious'* when they were informed of the medication error. Patient A was discharged a few days later with no further complications.

Witness 1 investigated the matter and recalls that Ms Howard admitted to her the medication error in relation to administration of warfarin in 2019. Witness 1 decided to stop Ms Howard from being allowed to administer medication or act as a second checker while the matter was investigated.

Between 1 April and October 2019, Ms Howard was on long term sick leave from the Trust. On 17 October 2019, Witness 5 met with Ms Howard to discuss the medication error of 21 March 2019 in which Ms Howard admitted administering 7 mg of Warfarin to Patient A instead of the prescribed 2 mg dose.

Witness 7 chaired a disciplinary hearing on 22 January 2020. From the minutes, the panel asked Ms Howard whether she had picked up that there was a potential issue when Patient A questioned the number of tablets; Ms Howard answered, *'No'*.

At the conclusion of the hearing, the Trust offered to downgrade Ms Howard to a Band 2 health care assistant. Ms Howard declined the offer. Ms Howard has not substantially engaged with the NMC and has not provided a substantive response to the regulatory concerns and charges.

Decision and reasons on facts

In reaching its decisions on the charges, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

The panel was 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 a fact will

be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Matron at Leicester Royal Infirmary at the time of the incidents.
- Witness 2: Sister at Leicester Royal Infirmary at the time of the incidents.
- Witness 3: Band 5 Nurse at Leicester Royal Infirmary at the time of the incidents.
- Witness 4: Deputy Sister at Leicester Royal Infirmary at the time of the incidents.
- Witness 5: Deputy Sister at Leicester Royal Infirmary at the time of the incidents.
- Patient A The Patient at the time.
- Witness 6: Head of Nursing at Leicester Royal Infirmary at the time of the incidents.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC.

The panel then considered each of the charges and made the following findings.

Charge 1

1. On or around 19 February 2016 administered medication, namely Lorazepam, to the wrong patient.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witnesses 1 and 2, the letter dated 29 September 2016, which was the first written warning and the summary of the medication errors which Ms Howard has admitted at the time. It also took into account the DATIX information and reports dated 20 February to 9 September 2016, meeting notes dated 8 September 2016, the Capability review documents and Ms Howard's reflective statement dated 6 March 2016.

The panel noted that Witness 1 states the following in her supplementary witness statement:

> *In my letter of first written warning to Ms Howard dated 29 September 2016 exhibited in my main statement at JC/01 it is stated: 'In mitigation you confirm that you fully accept responsibility for the errors that occurred'. Based on this information it appears that Ms Howard also admitted the three 2016 medication errors at the hearing on 26 September 2016.*

The panel also noted the numerous documents which detail the incident, namely the DATIX reports, the meeting notes, the Capability review document and Ms Howard's own reflective statement.

The panel acknowledged that Ms Howard admitted making the medication error at the time of the investigation and she was disciplined in relation to the incident. There was no evidence before the panel to suggest that this incident did not take place. It therefore finds this charge proved.

Charge 2

2. On or around 28/29 August 2016 failed to attend the patient's bedside when acting as a second checker for intravenous medication, namely Flucloxacillin.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witnesses 1 and 2, the first written warning dated 29 September 2016, the DATIX information and reports dated 20 February to 9 September 2016, meeting notes dated 8 September 2016, the Capability review documents and the emails from Witness 2 and Person 7.

The panel noted that Ms Howard did not dispute this error occurring at the time of the incident. It also noted the documentation as a result of the incident detailing the action taken after the fact to discipline and support Ms Howard going forward.

The panel acknowledged the DATIX report which clearly detailed the incident.

The panel was satisfied based on the information before it that the incident took place and in light of Ms Howard's admission, it therefore finds this charge proved.

Charge 3

3. On or around 1 September 2016 administered intravenous fluids/medication which was not prescribed.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witnesses 1 and 2, the first written warning dated 29 September 2016, the DATIX information and reports dated 20 February to 9 September 2016, the telephone note dated 4 September 2016 and the email from Person 7 dated 5 September 2016 and the Capability review documents.

The panel considered the email from Person 7 dated 5 September 2016, which outlined the medication Ms Howard incorrectly administered on 1 September 2016 to a patient.

The panel acknowledged Ms Howard's admissions that she should not have administered this medication and considered all the documentation that supports the medication error.

The panel was therefore satisfied that the error had taken place and it finds this charge proved.

Charge 4a

4. On 1 April 2017:

a) Administered the incorrect medication to Patient C, namely 20mg of immediate release Oxycodone instead of the prescribed 20mg prolonged release Oxycodone;

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witnesses 1 and 2, the first written warning dated 29 September 2016, the DATIX report dated 1 April 2017, the Capability review documents and the Improvement performance hearing letters dated 12 September 2016 and 3 April 2017.

The panel acknowledged the DATIX report which outlines the medication error and all the evidence which demonstrates this error took place, the date on which it happened and the action that took place afterwards. The panel also acknowledged Ms Howard does not dispute this error took place.

Based on all the information before it the panel therefore finds this charge proved.

Charge 4b

4. On 1 April 2017:

b) Made the medication error in 4(a) above whilst you were subject to a first written warning for capability.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witnesses 1 and 2, the first written warning dated 29 September 2016, the DATIX report dated 1 April 2017, the Capability review documents and the Improvement performance hearing letters dated 12 September 2016 and 3 April 2017.

The panel considered the evidence that Ms Howard being subject to an Improvement Notice was informed in the first written warning that should there be any medication errors within a year of the warning that further action would be taken.

The panel further noted that Ms Howard does not deny the error took place and was compliant with the disciplinary action that was taken as a result.

The panel was therefore satisfied that the error did take place and it therefore finds this charge proved.

Charge 5

5. On 21 March 2019 administered an incorrect dose of medication, namely 7mg of Warfarin to Patient A.

This charge is found proved.

In reaching this decision, the panel took into account Patient A's witness statement and the EPMA chart along with the witness statements of Witnesses 1, 2, 3, 4 and 5 the contemporaneous notes completed by all the witnesses. It also took into account the meeting notes dated 29 March 2019 5 April 2019, 24 May 2019 and 17 October 2019, the DATIX report and email from Witness 1 dated 23 March 2019.

The panel considered the witness statement of Patient A who had raised a concern over the amount of tablets they were required to take with Ms Howard, and that they thought the dosage was incorrect.

The panel also took into account the contemporaneous notes from the staff on duty, which confirmed the incident took place. The panel also acknowledged Ms Howard's admissions at the time in relation to this incident.

The panel therefore, based on all the evidence before it finds this charge proved in that Ms Howard did administer the incorrect dosage to Patient A.

Fitness to Practice

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether Ms Howard's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. Firstly, the panel must determine whether the facts found proved amount to a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, Ms Howard's fitness to practise is currently impaired as a result of that lack of competence.

Representations on lack of competence and impairment

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 NMC invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Ms Howard's actions amounted to a lack of competence. A lack of competency needs to be assessed using a three-stage process:

- Is there evidence that Ms Howard was made aware of the issues around her competence?
- Is there evidence that Ms Howard was given the opportunity to improve?
- Is there evidence of further assessment?

The NMC invited the panel to find that the facts found proved show that Ms Howard's competence at the time was below the standard expected of a band 5 registered nurse.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Ms Howard's fitness to practise impaired on the grounds. It is submitted that it the panel can answer yes, to the three questions set out above regarding Ms Howard's lack of competence.

The NMC submitted that Ms Howard's repeated medication errors over a long period of time between 2016 and 2019 despite the relevant support provided to her at work raise an obvious risk of harm to patients.

Nurses occupy a position of privilege and trust in society and are expected at all times to maintain an adequate standard of competence. 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 standard of competence at all times justifies both their patients' and the public's trust

in the profession. As such Ms Howard's lack of clinical competence is liable to bring the nursing profession into disrepute.

At the relevant times, Ms Howard was subject to the provision of the Code. The NMC suggested parts of the Code that Ms Howard breached, due to her lack of competence for the panel's consideration.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons 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 Code. In particular, the following standards:

> ***6 Always practise in line with the best available evidence***
> *To achieve this, you must:*
> *6.2 maintain the knowledge and skills you need for safe and effective practice.*
>
> ***18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations***
> *To achieve this, you must:*
> *18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs*
> *18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drug*
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***

To achieve this, you must:
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

The panel bore in mind, when reaching its decision, that Ms Howard should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

In the panel's judgement, Ms Howard's actions in each of the individual charges found proved did fall seriously short of the conduct and standards expected of a nurse and amounted to a lack of competence. It also noted Ms Howard's admissions as set out in the various meeting notes, which took place after each incident.

Ms Howard's failures had the potential to cause significant harm to patients and undermined public confidence in the profession. The panel determined that the numerous errors in medication administrations were basic fundamental nursing skills. Although, Ms Howard was made aware of the numerous errors in her medication administration and received support, she then repeated the errors.

Taking into account the reasons given by the panel for the findings on the facts, the panel has concluded that Ms Howard's practice was below the standard that one would expect of the average registered nurse acting in Ms Howard's position.

In all the circumstances, the panel determined that Ms Howard's performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Ms Howard'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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

The panel bore in mind this was a lack of competence case, nevertheless the panel had regard to the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* 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.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'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/their fitness to practise is impaired in the sense that S/He/They:*
>
> 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 patients were put at risk and there was a potential for physical and emotional harm as a result of Ms Howard's lack of competence. The panel determined that Ms Howard's lack of competence has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel went on to consider whether Ms Howard remained liable to act in a way that would put patients at risk of harm, would bring the profession into disrepute and breach the fundamental tenets of the profession in the future. In doing so, the panel considered whether there was any evidence of insight and remediation.

The panel carefully considered the documentation and found that there was some evidence that demonstrated limited insight when Ms Howard repeatedly accepted the errors at the time. Additionally, the panel noted that there was evidence of a challenging and pressurised working environment and circumstances in her personal life which might have adversely affected Ms Howard's ability to practise safely and professionally.

Regarding insight, the panel considered Ms Howard's reflective piece and her admissions at the time and that she had developing insight. The panel has not been able to ascertain her current level of insight and therefore it was unable, with confidence to accept that Ms Howard had demonstrated anything other than limited insight into her lack of competence or that she had considered the impact on patients, colleagues, the reputation on the profession and the wider public interest.

In its consideration of whether Ms Howard has taken steps to strengthen her practice, the panel had no information from her since the incidents and her dismissal to demonstrate any steps Ms Howard may have taken. In light of this, the panel is of the view that there is a risk of repetition as there is no evidence based to demonstrate any strengthening of her practice Ms Howard may have undertaken. The panel therefore decided 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 well-being of the public and patients, and to uphold, protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Ms Howard'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 evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 18 July 2023, the NMC had advised Ms Howard that it would seek the imposition of a conditions of practice order for a period of 18 months, with a review before its expiry, if it found Ms Howard's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Ms Howard's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne 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 SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Repeated medication administrations errors over 3 years despite appropriate reflection and additional support at local level;
- Potential for patient harm; and
- Conduct which put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- Ms Howard's early admissions of her medication errors;
- Ms Howard's local reflections;
- Contextual factors such as :
  (i) pressure in the work environment and
  (ii) patients' challenging behaviour.
- Ms Howard's willingness to accept support at local level;
- Pressure in her personal life that could impact on her performance at work; and
- Ms Howard was described by colleagues as caring and compassionate nurse and always willing to help others.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Howard's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Howard's misconduct was not at the lower end of the spectrum and that a caution order would be

inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Howard's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that Ms Howard was willing to comply with support similar to conditions of practice in the past and may be willing to comply with conditions of practice order.

The panel had regard to the fact that these incidents happened a long time ago and that, other than these incidents, Ms Howard has had an unblemished career over a number of years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, Ms Howard should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel did consider more restrictive sanctions, but it was of the view that to impose a suspension order at this stage would be wholly disproportionate and would not be a

reasonable response in the circumstances of your case. The panel acknowledged that a striking-off order was not an available sanction due to the type of 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:

> '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.

1. You must not administer medication, whether orally, via injection or infusion unless directly supervised by another nurse until such time that you have been signed off as competent by your line manager, mentor, or supervisor (who must be a registered nurse).

2. You must ensure that you are supervised by a registered nurse any time you are working. Your supervision must consist of:

    - Working at all times on the same shift as, but not always directly observed by a registered nurse.

    - You must identify a personal development plan with your line manager, mentor or supervisor and keep a log of your progress towards addressing medicine administration.

3. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from either your line manager, mentor or supervisor detailing your progress including the plan, log and any training.

4. You must provide a reflective piece for a reviewing panel covering the area of concern identified.

5. You must keep the NMC 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.

6. You must keep the NMC 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.

7. 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.

8. 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.

9. 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 period of this order is for 12 months.

The panel determined that this was the minimum time necessary for Ms Howard to find a nursing job and demonstrate adherence to the conditions as outlined above.

Before the end of the period of the order, a panel will hold a review hearing to see how well Ms Howard 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 for another order.

Any future panel reviewing this case would be assisted by:

- Evidence of Ms Howard's compliance with the conditions of practice order;
- Ms Howard's attendance at future review hearings;
- An indication of Ms Howard's future intentions in relation to her nursing career; and
- Testimonials and/or references from any work paid or otherwise.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is

necessary for the protection of the public, is otherwise in the public interest or in Ms Howard's own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that if Ms Howard's fitness to practise is impaired on a public protection basis and a restrictive sanction imposed, the NMC considers an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of 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.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as 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 for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.

This will be confirmed to Ms Howard in writing.