Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday 11 – Friday 12 June 2026
Monday 15 June 2026

Virtual Meeting

Name of Registrant:	Elaine Paula Ward
NMC PIN:	98I6081E
Part(s) of the register:	Registered Nurse – Sub Part 1 Registered Children's Nurse L1 – September 2001
Relevant Location:	Dorset
Type of case:	Misconduct
Panel members:	Susan Thomas (Chair, Lay member) Fay Jackson (Lay member) Julia Briscoe (Registrant member)
Legal Assessor:	Charlene Bernard
Hearings Coordinator:	Shela Begum
Facts proved:	Charges 1a, 1b, 1c, 2b and 3b
Facts not proved:	Charges 2a, 3a and 3c(i) and 3c(ii)
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (18 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 the Notice of Meeting had been sent to Mrs Ward's registered email address by secure email on 27 April 2026.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation and that the meeting would be held on or after 1 June 2026. The panel noted that subsequent to the Notice of Meeting being served, Mrs Ward provided written representations to the NMC dated 27 May 2026.

In the light of all of the information available, the panel was satisfied that Mrs Ward 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).

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision and reasons for parts of the determination to be marked private

[PRIVATE].

Details of charge

That you, a registered Nurse

1. On 13 May 2022:
    a. Failed to verify Patient B's identity before administering medication.
    b. Administered medication to Patient B that was meant for Patient A.
    c. Failed to administer medication to Patient A.
2. On 20 May 2022, in relation to Patient C, you:
    a. Failed to check the stomach pH level.
    b. Administered milk via a nasogastric tube when the pH level was too high.
3. Failed to keep accurate records, in that:
    a. On 13 May 2022 you failed to record details of medication that had been incorrectly administered to Patient B
    b. On 13 May 2022 you recorded in Patient A's MAR chart that medication had been administered when it had not
    c. On 20 May 2022 failed to complete the Nasogastric tube confirmation for Patient C timed for:
        i. 08:00
        ii. 09:00

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

Background

Mrs Ward was referred to the Nursing and Midwifery Council (NMC) by Dorset County Hospital NHS Foundation Trust on 15 July 2022 following two alleged clinical incidents which occurred during the course of her employment at the Trust in May 2022. At the time of the events giving rise to these proceedings, she worked on Kingfisher Ward, a paediatric ward.

The first alleged incident occurred on 13 May 2022 and concerned the administration of amoxicillin to a paediatric patient. It is alleged that Mrs Ward administered amoxicillin to Patient B, a 14-month-old child, when the medication had been prescribed for Patient A, a five-year-old child. It is further alleged that Mrs Ward failed to verify Patient B's identity prior to administering the medication and, as a consequence, failed to administer the prescribed medication to Patient A.

The second alleged incident occurred on 20 May 2022 and involved the administration of a milk feed via a nasogastric tube to Patient C. It is alleged that Mrs Ward failed to check the patient's stomach pH level and administered the feed despite the pH level being recorded at 7.5, above the accepted upper limit of 5.5. It is further alleged that Mrs Ward failed to complete the nasogastric tube confirmation records for Patient C at 08:00 and 09:00.

In addition, concerns were raised regarding the accuracy and completeness of Mrs Ward's record keeping. It is alleged that she failed to record details of the medication incorrectly administered to Patient B and inaccurately documented in Patient A's medication administration record that amoxicillin had been administered when it had not.

Following the incidents, the Trust undertook a local investigation and disciplinary process, culminating in a disciplinary outcome letter dated 15 July 2022.
Mrs Ward subsequently obtained employment with Somerset NHS Foundation Trust, from which she resigned in June 2023. [PRIVATE].

Decision and reasons on facts

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

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:

- Yvonne Lee: Clinical Lead for Temporary Staffing, Dorset County Hospital NHS Foundation Trust
- Sarah Woodward: Interim Paediatric Matron, Kingfisher Ward, Dorset County Hospital NHS Foundation Trust

The panel also had regard to written representations from Mrs Ward.

The panel accepted the advice of the legal assessor.

It considered the documentary evidence provided by both the NMC and Mrs Ward.

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

Charge 1a

1. On 13 May 2022:
    a. Failed to verify Patient B's identity before administering medication.

This charge is found proved.

In reaching this decision, the panel considered the documentary evidence, including the witness statement of Yvonne Lee dated 17 April 2024, the Local Investigation Report, the minutes of Mrs Ward's investigation meeting held on 9 June 2022, and the Trust's medicines policy.

The panel noted that Patient A was a five-year-old child who had been prescribed amoxicillin and Patient B was a fourteen-month-old child.

The panel had regard to paragraph 16 of Yvonne Lee's statement, in which she stated:

> *"Neither Patient A nor Patient B were wearing ID wristbands at the time of the incident. During the investigation, I was told that Patient A and Patient B had not been formally admitted to Kingfisher Ward as they were in the Patient Assessment Unit ("PAU"). All nurses spoken to as part of the investigation said that it was not unusual for children not to wear ID wristbands and that where this was the case, the wristband would be printed and attached to the top of the patient's notes. In her interview (point six of exhibit YL/15), Tracy confirmed that where a patient is not wearing an ID wristband, normal practice is to check with the patient's identity with their parents. I believe this process is not written into policy, it just tended to be the practice done on the ward. Tracy confirmed that the parents of Patient A and Patient B were present at all times, so Elaine could have checked identities with them."*

The panel accepted the evidence that, in the absence of an identification wristband, the normal practice on the ward was to verify a patient's identity with their parents.

The panel had regard to the Trust notes from the meeting with Mrs Ward held on 9 June 2022 which records Mrs Ward's account given at the time: It states:

> *"YL asked what the normal administration procedure is for giving medication, EW explained that there is a system called JACS which is on the computer, however you cannot bring the computer to the patient, therefore you have to check the drug,*

the dose and then give to the patient. YL asked if the patients would have had ID wrist bands, EW confirmed that they wouldn't get a wristband until they are admitted to the ward. YL asked how EW would normally identify a patient, EW said that she would check with the parent that it is the correct patient, YL asked if in this case she asked the parent who the patient is, EW said that she didn't because she was too busy. YL asked if when EW was drawing up the medication did it spring to mind the size of the dose, EW said she didn't have time to think about it as the ward was busy."

The panel had regard to the evidence that neither Patient A nor Patient B was wearing an identification wristband at the time. The panel accepted the evidence of Yvonne Lee, corroborated by Mrs Ward's account during the investigation, that where a patient was not wearing an identification wristband, the usual practice on the ward was to verify the patient's identity with their parent.

The panel noted that the parents of both patients were present. The panel was satisfied that Mrs Ward had a duty to verify Patient B's identity prior to administering medication. The panel was satisfied that, in the absence of a patient wristband, she was required to verify the patient's identity with the parent before administering the medication. The panel further accepted Mrs Ward's account that she did not ask the parent to confirm the patient's identity before administering the medication.

The panel accepted that the ward was busy and that Mrs Ward may have been affected by an earlier unrelated meeting that she attended with Sarah Woodward and an HR representative. However, the panel considered that these circumstances did not absolve her of the responsibility to undertake the necessary identity checks before administering medication. Accordingly, the panel found that Mrs Ward failed to verify Patient B's identity before administering medication.

Charge 1b

1. On 13 May 2022:
    a. [...]
    b. Administered medication to Patient B that was meant for Patient A.

This charge is found proved.

In reaching this decision, the panel considered the documentary evidence, including the witness statement of Yvonne Lee dated 17 April 2024, the contemporaneous note attached to Tracy King's email dated 16 May 2022, the medication administration records, and the notes of the investigation meeting held with Mrs Ward on 9 June 2022.

In relation to charge 1b, the panel noted Yvonne Lee's witness statement, in which she stated:

> *“14. On 13 May 2022, Elaine gave a dose of amoxicillin to Patient B that was prescribed to Patient A. She subsequently recorded in the MAR for Patient A that Patient A had been administered the dose which she had given to Patient B. Amoxicillin is a penicillin based, widely used antibiotic used to treat various infections. I understand that Patient A had been prescribed amoxicillin as there were respiratory infection concerns.”*

The panel considered the contemporaneous account provided by Tracy King, who described the events of 13 May 2022. The contemporaneous note detailing the incident was attached to an email dated 16 May 2022 which set out that Ms King instructed Mrs Ward to administer Patient A's prescribed amoxicillin whilst she was on a break. Upon Ms King’s return, Mrs Ward informed her that Patient A had received all prescribed medication.

The contemporaneous note stated:

> *“On my return I asked Elaine for an update. She said that [Patient A] had been given all her prescribed medications but that her nebulisers had been switched to inhalers. She also said that [Patient B] had been commenced on "BURST" therapy inhalers.*

I went to re-assess [Patient A] and was a bit confused as she had a nebuliser running. I asked the PANP Hannah and the Paediatric SpR Alyssa why [Patient A] was still on nebulisers as I had been told she had now been switched to inhalers They corrected me, explaining that it was [Patient B] on inhalers, not [Patient A]. I assumed that I had misheard Elaine when she had updated me.
SpR Alyssa then asked to speak to me privately. She asked me if I had given any oral amoxicillin to [Patient B] in the treatment room. I said that I had not but that I had asked Elaine to give amoxicillin to [Patient A] in bed 16 whilst I was on my break.
SpR Alyssa asked if I would check with Elaine who she gave the amoxicillin to, as [Patient B]'s mum had been quite clear that a nurse had given her daughter "some yellow medicine".
I asked Elaine: "Which patient did you give the oral antibiotics to? She replied "[Patient A]".
I asked " You definitely gave it to [Patient A] in bed 16?" She said "Yes".
I pointed to bed 15 (the treatment room) and said "So, you definitely didn't give any antibiotics to [Patient B]?" She said "No".
I checked the JAC system and saw that the chart for [Patient A] had a dose of amoxicillin prescribed that had been signed for by "SN. Elaine Ward" at 1824hrs.
I reassured SpR Alyssa that [Patient B] had not been given any oral antibiotics and that, according to both Elaine & the JAC chart, [Patient A] had been given amoxicillin at 1824hrs
At this point I remembered when Elaine had told me earlier in the day that [Patient A] had been switched to inhalers, when in reality she hadn't and was continuing on "back to back" nebulisers. I became very worried that, perhaps I hadn't misheard Elaine earlier at all - maybe Elaine had confused the two patients.
[…]
I asked [Patient A]'s mum: " Has [Patient A] had her antibiotics yet?" She replied "No, she's just had her nebulisers and a clear fluid that they told me was steroids" (dexamethasone).
I then asked [Patient B]'s mum: "Could you just clarify with me what medications [Patient B] has had today please?". She said, " I gave her calpol at home this morning and, since she's been here, she's had 3 lots of puffers and some yellow medicine". I asked her "Who gave [Patient B] the yellow medicine?"

And she said "The other nurse. The one with blonde hair". At this point Elaine entered the treatment room and the [Patient B]'s mum pointed at her and said "It was her".
As Elaine and I left the treatment room, Elaine asked me "Have I done something wrong?" I took Elaine to a private space and explained that, although she had told me that she had given [Patient A] oral antibiotics and signed accordingly on JAC, [Patient A]'s mum says she hasn't had them. And, although she told me specifically she hadn't given any antibiotics to [Patient B], her mum is sure that her daughter had been given some "yellow medicine" and that she had identified Elaine as the nurse who administered it."

The panel further noted Tracy King's account of her subsequent discussion with Mrs Ward, during which she explained that she believed a medication error had occurred. Tracy King recorded that Mrs Ward reacted by:

"holding her head in her hands and saying 'Oh no - I feel terrible! This is not gonna do me any favours as 'they' already think I'm incompetent!'"

The panel considered this response to amount to an acknowledgment that an error had been made.

The panel had regard to the Trust notes from the meeting with Mrs Ward held on 9 June 2022, which states:

"YL asked for EW to explain what happened on the day of the first allegation, EW said that she was allocated to the Pre-Assessment Unit (PAU) said that it was busy with only 2 Nurses covering the 8 patients, multiple children were on burst therapy inhalers. EW said that she was asked to give a patient Amoxicillin, EW said that she gave this to the wrong patient but didn't realise, YL asked if both children were on burst therapy inhalers, EW confirmed that they were. YL asked if EW was in charge of both patients, EW explained that patients on PAU were not allocated all staff looked after them all. EW said that it was easy to get confused, YL asked if both of the children were in close proximity to each other, EW said that they were next door to each other. YL asked what time the incident happened, EW confirmed that it was

early evening. YL asked if the day had been normal, EW said that in the morning she had a formal meeting which she had not been told about which made her angry and upset and not a good way to start the day, EW said that she probably wasn't thinking straight, YL asked if support was offered, EW stated that there wasn't"

The panel also had regard to Mrs Ward's written response to the regulatory concerns in which she stated:

"I ticked yes, as I did administer the wrong drug to the wrong patient. This was a mistake, and I didn't realise what I had done, until I was challenged."

Having considered the evidence in its entirety, the panel accepted that Mrs Ward was asked to administer Patient A's prescribed amoxicillin. The panel also accepted Tracy King's contemporaneous account that, when asked which patient had received the antibiotic, Mrs Ward confirmed it had been given to Patient A, and the medication administration record showed that Mrs Ward signed for amoxicillin in respect of Patient A at 18:24 hours. The panel further noted the evidence from Patient A's mother that Patient A had not received antibiotics, and the evidence from Patient B's mother that her child had been given "some yellow medicine" by "the other nurse, the one with blonde hair", whom she identified as Mrs Ward. The panel also had regard to Mrs Ward's account during the investigation meeting that she "gave this to the wrong patient but didn't realise". Taken together, the panel was satisfied that Mrs Ward administered the amoxicillin prescribed for Patient A to Patient B. Accordingly, the panel found charge 1b proved.

Charge 1c

1. On 13 May 2022:
    a. [...]
    b. […]
    c. Failed to administer medication to Patient A.

This charge is found proved.

In reaching this decision, the panel considered the documentary evidence, including the witness statement of Yvonne Lee dated 17 April 2024, the contemporaneous note

attached to Tracy King's email dated 16 May 2022, and the notes of the investigation meeting held with Mrs Ward on 9 June 2022.

The panel noted the evidence supporting Charge 1b that Mrs Ward administered amoxicillin intended for Patient A to Patient B.

The panel considered the contemporaneous account provided by Tracy King, who recorded:

> *“i asked Elaine to give [Patient A] the third & final "back-to-back" nebuliser as well as her oral dexamethasone & amoxicillin and then, to liaise with the doctors once they had assessed [Patient B] to establish if she needed any immediate treatment.*
> *[…]*
> *On my return I asked Elaine for an update. She said that [Patient A] had been given all her prescribed medications but that her nebulisers had been switched to inhalers. She also said that [Patient B] had been commenced on "BURST" therapy inhalers.”*

The panel understood from this evidence that responsibility for administering Patient A's prescribed amoxicillin had been delegated to Mrs Ward whilst Tracy King was on her break and that Mrs Ward accepted this responsibility for this duty.

The panel further considered Tracy King's contemporaneous account that, following identification of the medication error:

> *“I administered the prescribed dose of amoxicillin to [Patient A] and added a note the entry signed by Elaine on JAC. I also documented the error on [Patient A]’s medical notes.*

The panel had regard to the Trust notes from the meeting with Mrs Ward held on 9 June 2022, which states:

> *“YL asked what happened with the child that should have had the Amoxicillin, EW said that Tracy King (TK) had given the child the medication.”*

The panel accepted that Patient A ultimately received the prescribed medication. However, the issue for the panel was whether Mrs Ward failed to administer the medication to Patient A when she was required to do so.

The panel was satisfied that the responsibility for administering the medication had been delegated to Mrs Ward and that she did not fulfil that responsibility. Instead, as found under Charge 1b, she administered the amoxicillin to Patient B in error. The panel considered that Tracy King subsequently administered the medication to Patient A and amended the records accordingly to provide clear evidence that Patient A had not received the prescribed medication from Mrs Ward and that intervention by another nurse was required to ensure that Patient A received the prescribed treatment. Accordingly, the panel was satisfied, on the balance of probabilities, that Mrs Ward failed to administer amoxicillin to Patient A. The panel therefore found charge 1c proved.

Charge 2a

2. On 20 May 2022, in relation to Patient C, you:
    a. Failed to check the stomach pH level.
    b. […]

This charge is found NOT proved.

In reaching this decision, the panel considered the documentary evidence, including the witness statement of Yvonne Lee dated 17 April 2024, the Local Investigation Report, the patient records, the email provided by Hayley Brown, and Mrs Ward's response to the regulatory concerns.

The panel noted Yvonne Lee's witness statement, which stated:

> *"Melissa had identified that Patient C's pH was 7.5. In this instance, Elaine should have followed the guidance set out in exhibit YL/14. She should not have proceeded with the feed. She should have raised the pH level with another competent clinician who could document confirmation of the NG tube position in the stomach. Patient C did not come to harm from receiving the milk feed when their pH was 7.5. Melissa rechecked the pH level and found that it was within an acceptable range after the*

feed had commenced. The primary concern with Elaine proceeding with the feed when the pH level was 7.5 was that the NG tube could have moved and would be in Patient C's lungs. If a feed is commenced when the NG tube is not in the stomach but in the lungs, this could result in aspirate pneumonia. Aspirate pneumonia is when fluid is inhaled into the lungs causing infection which could have fatal consequences. Litmus paper is a strip of paper that changes colour in the presence of acid or alkaline. Trust policy (exhibit YL/14) states at 2.5.6 that Litmus paper should never be used for aspiration testing, no matter the circumstances. My understanding is that this was the case following a national review of best practice for NG tubes which found that interpretation was not accurate and that there were better available testing strips. Litmus paper gives a colour to represent the pH level rather than a number. I am not aware that Elaine used Litmus paper to test Patient C's pH level, however, she referred to her preference for using it when interviewed and that she had used it in previous trusts as she found it easier. We do not keep Litmus paper at the Trust. To use Litmus paper would go against best practice and Trust policy.
Patient C's NG tube position confirmation record (exhibit YL/13) was incomplete. There were no entries made between the recorded feeds at 04:30 and 10:30. The regularity of these recordings depends on the child's feeding regime. The record states that the position of the NG tube should be checked before each feed. I believe that there had been a change as the mother was also breast feeding but it had become difficult for the baby to breathe when feeding, hence the introduction of the NG tube."

The panel had regard to the Local Investigation Report, which records:

"EW was made aware of a high pH level of 7.5 by ME when administering a young baby a milk feed. EW had aspirated the NG tube as per protocol prior to the feed as confirmed in her statement. EW stated that she thought it read 5.5 and was safe to proceed with an hourly milk feed."

The panel also considered Mrs Ward's response to the regulatory concerns, in which she stated:

"*I did fail to follow the correct NGT protocol, as when I did the feed I glanced at the PH paper, rather than compare to the pH testing tube pot, which would have provided more accuracy*."

The panel considered this to relate to the manner in which the result was interpreted rather than whether a pH reading had been obtained.

The panel further considered the email from Hayley Brown dated 9 June 2022, which described difficulty obtaining an aspirate and recording an initial reading of "7+ on the pH test strips," followed by administration of a small amount of milk and subsequent aspiration showing "5.5 on the PH test strips," after which it was stated that it was "fine to carry on with the feed."

The panel accepted that there were differing accounts regarding the precise pH value recorded and concerns regarding interpretation of the result and subsequent clinical decision-making. The panel accepted that there may have been concerns regarding Mrs Ward's interpretation of the pH result and her compliance with the Trust's NG tube guidance. However, the panel considered that these matters were more properly directed towards whether Mrs Ward proceeded with the feed when the pH level was too high, rather than whether she carried out the pH check itself. The panel was satisfied that the evidence established that Mrs Ward aspirated the NG tube and obtained a pH reading prior to administering the feed. Although the panel considered that she may have misread or misinterpreted that result, it was not persuaded that the evidence established, on the balance of probabilities, that she failed to check Patient C's stomach pH level. Accordingly, the panel found charge 2a not proved.

Charge 2b

2. On 20 May 2022, in relation to Patient C, you:
    a. […].
    b. Administered milk via a nasogastric tube when the pH level was too high.

This charge is found proved.

In reaching this decision, the panel considered the documentary evidence, including the witness statement of Yvonne Lee dated 17 April 2024, the patient records, the Local Investigation Report, Mrs Ward's response to the regulatory concerns, and the Trust's guidance relating to nasogastric tube management.

The panel had regard to Yvonne Lee's witness statement which set out:

> *"Melissa had identified that Patient C's pH was 7.5. In this instance, Elaine should have followed the guidance set out in exhibit YL/14. She should not have proceeded with the feed. She should have raised the pH level with another competent clinician who could document confirmation of the NG tube position in the stomach."*

Yvonne Lee's evidence further explained the potential consequences of administering a feed when the pH level was too high:

> *"The primary concern with Elaine proceeding with the feed when the pH level was 7.5 was that the NG tube could have moved and would be in Patient C's lungs. If a feed is commenced when the NG tube is not in the stomach but in the lungs, this could result in aspirate pneumonia."*

The panel considered the patient chart, which recorded a pH level of 4.5 at 08:00, 7.5 at 09:00 and 5.0 at 10:40. The panel noted that the 09:00 pH entry appeared to be in different handwriting and included initials indicating that the result had been rechecked by Sarah Woodward and Melissa Eveleigh.

The panel also had regard to the Local Investigation Report which records:

> *“EW was made aware of a high pH level of 7.5 by ME when administering a young baby a milk feed. EW had aspirated the NG tube as per protocol prior to the feed as confirmed in her statement. EW stated that she thought it read 5.5 and was safe to proceed with an hourly milk feed.”*

The panel had regard to the Trust notes from the meeting with Mrs Ward held on 9 June 2022, which states:

> *“YL asked ME whether she was present at both allegations, ME confirmed that she was not working on the 13 May but was present on the 20 May during the second allegation. YL asked ME to explain what happened on this day, ME said that on the 20" May 2022 she was the Nurse in Charge on the day shift, ME said that she allocated patients to staff, ME explained that she gave a less complex case to EW and this was a child that needed feeds as she knows EW had experience with neonatal children. ME said that she went into the bay to introduce herself to the parents and discretely check the work that EW had done, ME said that she could see that the pH was at 7 which is too high and the feed had been carried out. YL asked how she knew it was at 7, ME said that it was clear on the pH strip, ME said that it is absolutely standard that the pH has to be checked in both children and adults, if the pH is more than 5 then you must not continue with the feed. ME said that she couldn't believe it and had to go back to check, YL asked if EW was actively giving the feed to the baby, ME confirmed that she was.”*

This evidence established that Melissa Eveleigh had personally observed the pH strip and it was clear that the result was above the acceptable range.

The panel further considered Mrs Ward's response to the regulatory concerns in which she stated:

> *"I ticked yes for concern number three as I did fail to follow the correct NGT protocol. As when I did the feed I glanced at the PH paper, rather than compare to the PH testing tube pot. Which would have provided more accuracy. It was very busy, and I was rushing, as I had lots of patients to look after. The sister in charge came into the cubicle to check up on me. By this point the feed had been running for five minutes. She asked about my PH and I said it was 5.5 and she glanced at it too, and said it was 5.5. She then decided to analyse it further and said it was 7.1."*

The panel noted that Mrs Ward did not dispute that she administered the feed. Rather, her position was that she had misread the pH result and believed it was safe to proceed.

The panel noted that the Trust guidance was that feeding should not continue if the pH level exceeds the permitted threshold, and that further advice should be sought.
The panel accepted that Mrs Ward believed the pH reading was 5.5. However, the panel was satisfied that the contemporaneous evidence established that the pH level was in fact 7 to 7.5 at the time the feed was administered and that this was above the acceptable range. The panel concluded that Mrs Ward administered milk via the nasogastric tube when the pH level was too high. Accordingly, the panel found charge 2b proved.

Charge 3

3. Failed to keep accurate records, in that:
    a. On 13 May 2022 you failed to record details of medication that had been incorrectly administered to Patient B

This charge is found NOT proved.

In reaching this decision, the panel considered the documentary evidence, including the witness statement of Yvonne Lee dated 17 April 2024, the Datix incident report, the contemporaneous account provided by Tracy King, the management investigation documents, and Mrs Ward's response to the regulatory concerns.

The panel noted that the evidence established that Mrs Ward did not complete a Datix report or otherwise document the medication error following its discovery.

The panel had regard to the Datix incident report and noted that it was completed by Tracy King. The panel also noted Tracy King's evidence that she documented the error in Patient A's medical records, informed senior colleagues, and escalated the matter to the paediatric consultant and matron.

The panel had regard to the disciplinary hearing outcome letter dated 15 July 2022 which recorded:

> *"You went through the management case and referred to point 3.3 and said that Tracey King is a Band 5 not Band 6 as stated. You referred to paragraph 3 of the summary of findings (issue 1) whereby it stated 'EW did not appear to recognise the error herself at the time of the event until challenged' you said that it wouldn't have*

been a mistake if you didn't know you'd done it. You said that you were mortified when you found out what had happened. You said that you were adamant you had given the amoxicillin to the right child. You referred to the same paragraph where it stated 'EW did not complete the DATIX form herself' you said that you had spoken with Paula Lewis, Junior Sister (PL) who had told you that Tracey King would do it, you said that you would have done the DATIX if you had been asked to do so. You the referred to the same paragraph where it states, 'EW has not completed the requested reflective statements following this […] as requested by the ward sister'. You said that you did this, and they were included as part of your evidence. It was confirmed that these had not been submitted by you during the course of the investigation nor had they been received prior to the hearing. "

The panel understood from the evidence that Tracy King, as the senior nurse involved, assumed responsibility for managing the incident by administering the medication to the correct patient, updating the medical records, completing the Datix report and escalating the matter to senior staff.

The panel acknowledged that nurses have a professional duty to be open and candid when errors occur. However, the issue for the panel was whether Mrs Ward had a specific responsibility to make the relevant records herself and whether she had failed to discharge that responsibility.

The panel was not satisfied that the evidence established, on the balance of probabilities, that Mrs Ward bore the sole responsibility for completing the records or that, in the circumstances, she had the opportunity to complete the records herself in any event. Accordingly, the panel found charge 3a not proved.

Charge 3b

3. Failed to keep accurate records, in that:
    b. On 13 May 2022 you recorded in Patient A's MAR chart that medication had been administered when it had not

This charge is found proved.

In reaching this decision, the panel considered the documentary evidence, including the medication administration record, the witness statement of Yvonne Lee dated 17 April 2024.

The panel noted Yvonne Lee's witness statement which stated:

> *"On 13 May 2022, Elaine gave a dose of amoxicillin to Patient B that was prescribed to Patient A. She subsequently recorded in the MAR for Patient A that Patient A had been administered the dose which she had given to Patient B."*

The panel considered the medication administration record, which showed that at 18:24 on 13 May 2022 Mrs Ward recorded that 640mg of amoxicillin had been administered to Patient A.

The panel noted that its finding in relation to Charge 1b established that Mrs Ward administered the medication to Patient B rather than Patient A. The panel also noted that Patient A's mother had confirmed that Patient A had not received any antibiotics at that time.

The panel accepted that Mrs Ward had signed the medication administration record believing that she had administered the medication to Patient A. However, the panel considered that the central issue was whether the record accurately reflected the care that had been provided.

The panel was satisfied that the medication administration record contained an inaccurate entry because it recorded that amoxicillin had been administered to Patient A when, in fact, it had not.

Accordingly, the panel found charge 3b proved.

Charge 3c

3. Failed to keep accurate records, in that:
    c. On 20 May 2022 failed to complete the Nasogastric tube confirmation for Patient C timed for:
        i. 08:00
        ii. 09:00

This charge is found NOT proved.

In reaching this decision, the panel considered the documentary evidence, including the witness statement of Yvonne Lee dated 17 April 2024, the feeding chart for Patient C, the nasogastric tube confirmation record, the Trust guidance for the management of nasogastric tubes, the investigation meeting notes, and the local statement of Hayley Brown.

The panel noted the Trust guidance at paragraph 2.5.1, which states:

> "*The position of an NGT should be checked after insertion, at least every 24 hours, before commencing a feed, before giving medication, after retching or vomiting, after chest physiotherapy, or following any evidence of displacement."*

The panel accepted that this guidance established a requirement to check and document the nasogastric tube position before each feed.

The panel considered the feeding chart, which recorded feeds administered at 08:00 and 09:00, together with corresponding pH readings of 4.5 and 7.5 respectively. The panel also noted that the nasogastric tube confirmation record at page 188 contained entries at 04:30 and 10:30 but no entries at 08:00 or 09:00.

The panel had regard to Mrs Ward's account during the investigation meeting that Patient C had been allocated to her and that the incident involving the high pH reading occurred during the second feed she had administered that morning.

However, the panel also considered the evidence of Hayley Brown, who stated that she had been asked by Sarah Woodward to administer an NG feed to Patient C and had sought advice from Sarah Woodward and Melissa Eveleigh after obtaining a high pH reading.

The panel noted that the available documentation did not identify which member of staff administered the feeds recorded at 08:00 and 09:00. The feeding chart did not contain signatures, and the evidence concerning the timing of the high pH reading and the involvement of different staff members was inconclusive and difficult to reconcile.

Whilst the panel accepted that the nasogastric tube confirmation record had not been completed at 08:00 and 09:00, the issue for the panel was whether it had been established, on the balance of probabilities, that Mrs Ward was responsible for those omissions.

The panel considered that the evidence did not enable it to determine with sufficient certainty which member of staff was responsible for completing the record at either of the relevant times. In particular, the panel could not exclude the possibility that other staff members involved in Patient C's care were responsible for one or both of the missing entries.

The panel therefore concluded that, whilst the records were incomplete, the NMC had not established that Mrs Ward was responsible for failing to complete the nasogastric tube confirmation record at 08:00 and 09:00. Accordingly, the panel found charge 3c not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Ward'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 ability to practise safely and effectively without restriction.

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. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the

facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Ward's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

The NMC invited the panel to take the view that the facts found proved amount to misconduct. 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 Mrs Ward's actions amounted to misconduct. In their statement of case, the NMC submitted:

> *"14. We consider the misconduct serious because Mrs Ward's actions, as detailed in the charges, fell so significantly short of what would be expected of a registered nurse that other professionals would find it [deplorable]. The areas of concern identified relate to clinical mistakes, medication mistakes, and inadequate record keeping. This misconduct was a significant departure from the fundamental principles of the Code of prioritising people, practising effectively, preserving safety, and promoting professionalism and trust in the professions."*

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) and any other cases referred to.

The NMC invited the panel to find Mrs Ward's fitness to practise impaired on the grounds of public protection and public interest. The NMC submitted:

> *"31. We consider there is a continuing risk to the public safety given the serious nature of the concerns which put patients at risk of harm. Therefore, the NMC considers that a finding of impairment is necessary in this case to protect the public from an unwarranted risk of harm.*
> *32. Further, Mrs Ward's conduct is unacceptable and has the potential to damage the reputation of the profession. Registered professionals occupy a position of trust and must provide a high standard of care. Mrs Ward's failure to do so has brought the profession into disrepute and is likely to bring the profession into disrepute in the future.*
> *33. Mrs Ward's failings have also breached fundamental tenets of the profession. Nurses are expected to provide a high standard of care and uphold the reputation of the profession. The failings in this case relate to fundamental nursing practice which raises serious concerns regarding Mrs Ward's ability to practise safely as a nurse.*
> *34. In Council for* ***Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)*** *at paragraph 74 Cox J commented that:*
> *"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."*
> *35. Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/or to maintain public confidence in the profession.*
> *36. In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which hasn't*

been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.

37. However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.

38. We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and [behaviour]. The actions of Mrs Ward fell below the professional standards required of a nurse.

39. The NMC therefore considers that a finding of impairment is necessary in this case to protect the public interest."

The panel accepted the advice of the legal assessor.

This 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 misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mrs Ward's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Ward's actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions […]

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

10 Keep clear and accurate records relevant to your practice

10.3 complete all records accurately […]

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

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

20 Uphold the reputation of your profession at all times

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

In relation to charges 1a, 1b and 1c, the panel considered that Mrs Ward's conduct constituted serious professional misconduct. The panel determined that the requirement to verify a patient's identity before administering medication is a fundamental and well-established principle of safe nursing practice. It is a basic safeguard designed to prevent avoidable medication errors and protect patients from harm. The panel found that, in circumstances where neither child was wearing an identification wristband, Mrs Ward failed to take alternative steps to verify Patient B's identity, despite accepted ward practice requiring staff to confirm a patient's identity with their parents. This failure resulted in medication prescribed for Patient A being administered to Patient B and a consequent failure to administer the medication to the intended patient. The panel considered that these failings resulted in Patient B receiving medication which had not been prescribed for them, while Patient A experienced a delay in receiving treatment. The panel bore in mind that both patients were young children and therefore particularly vulnerable. The panel was satisfied that these failings represented more than an isolated lapse or error of judgment. They arose from a failure to undertake a basic and essential safety check which lies at the heart of safe medicines administration. The panel concluded that Mrs Ward's

conduct fell seriously short of the standards expected of a registered nurse and amounted to serious professional misconduct.

In relation to charge 2b, the panel considered that Mrs Ward's conduct also amounted to serious professional misconduct. The panel found that Mrs Ward administered a milk feed via a nasogastric tube despite the pH level being above the accepted threshold. The panel considered that checking and correctly interpreting pH readings before commencing a feed is a critical safety measure intended to ensure that the tube remains correctly positioned within the stomach. The panel noted that clear Trust guidance required staff not to proceed with feeding where the pH level exceeded the accepted range and to seek further assessment before continuing. Mrs Ward failed to follow this guidance. The panel accepted the evidence that administering a feed through a displaced nasogastric tube carries a risk of aspiration pneumonia and potentially fatal consequences. Whilst no actual harm occurred in this case, the panel considered that the absence of harm did not diminish the seriousness of the conduct. The panel determined that Mrs Ward's actions created a risk of serious harm to a vulnerable infant and represented a serious departure from established safety procedures. The panel therefore concluded that charge 2b amounted to serious professional misconduct.

In relation to charge 3b, the panel considered that accurate record keeping is a fundamental requirement of nursing practice and essential to ensuring patient safety and continuity of care. The panel recognised that inaccurate medication records have the potential to mislead colleagues and adversely affect clinical decision-making. However, the panel also recognised that this inaccurate entry arose directly from Mrs Ward's mistaken belief that she had administered the medication to the correct patient. The panel considered that, viewed in isolation, this failing would not have been sufficiently serious to amount to serious professional misconduct. Nevertheless, the panel concluded that charge 3b could not properly be viewed in isolation. The inaccurate record formed part of the sequence of events arising from the medication administration error and contributed to the risk that Patient A would not receive the prescribed medication or could subsequently receive a duplicate dose. When considered alongside the findings under charges 1a, 1b and 1c, the panel concluded that charge 3b reinforced the pattern of unsafe practice identified and formed part of the serious professional misconduct found. The panel acknowledged the evidence that Mrs Ward was working in a busy and

pressured environment. However, the panel determined that the professional standards relating to patient identification, medicines administration, record keeping and the safe management of nasogastric feeding are fundamental safeguards intended to protect patients, particularly vulnerable children, in challenging clinical settings.

The panel concluded that Mrs Ward's conduct represented serious departures from the standards expected of a registered nurse and were sufficiently serious to amount to serious professional misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Ward's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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 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 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 determined that limbs (a), (b) and (c) are engaged in this case.
The panel found that Mrs Ward's misconduct placed patients at an unwarranted risk of harm. Her failure to undertake basic patient identification checks resulted in amoxicillin being administered to the wrong child and a delay in the intended patient receiving prescribed treatment. In relation to the nasogastric tube incident, Mrs Ward administered a milk feed when the pH level was above the accepted threshold, creating a risk of aspiration pneumonia and potentially serious consequences.

Although no actual harm occurred, the panel considered this to be fortuitous and determined that Mrs Ward's actions created a real risk of significant harm to vulnerable patients.

The panel further concluded that Mrs Ward's misconduct breached fundamental tenets of the nursing profession, including the requirements to administer medicines safely, maintain accurate records, and prioritise patient safety.

The panel was satisfied that her conduct brought the reputation of the profession into disrepute. By failing to comply with the fundamentals of nursing care creating a significant risk of harm to particularly vulnerable patients was serious misconduct which could cause damage to the reputation of the profession.

In considering insight, the panel noted that Mrs Ward made admissions in relation to several of the concerns. She accepted that she had administered amoxicillin to the wrong patient and acknowledged that she had failed to follow the correct nasogastric tube protocol. The panel also noted that Mrs Ward expressed remorse and apologised for her actions.

However, the panel considered that Mrs Ward's insight remained limited and had not fully developed. The panel noted that the Trust investigation report documented that Mrs Ward's commented that she "didn't know why she was being investigated" and that "no harm was done and nobody died." The panel considered these comments to demonstrate a focus on the absence of actual harm rather than an appreciation of the significant risk of harm created by her actions.

The panel determined that Mrs Ward had not demonstrated a sufficient understanding of the seriousness of her failings or of the fundamental importance of the safeguards she failed to follow. In particular, the panel was not satisfied that she had fully recognised that patient identification checks, adherence to nasogastric tube protocols and accurate record keeping are basic and essential components of safe nursing practice. The panel was not satisfied that Mrs Ward had demonstrated a sufficient understanding of how her actions gave rise to the concerns identified or the steps she would take to prevent similar incidents from occurring in the future. In particular, the panel considered that she had not fully reflected on the importance of adhering to fundamental patient safety measures, even in busy, difficult and pressurised clinical environments.

The panel also considered that Mrs Ward had not demonstrated a full understanding of the wider impact of her conduct on public confidence in the profession or on the trust placed in registered nurses to administer medication safely and maintain accurate records. Whilst the panel accepted that Mrs Ward recognised that errors had occurred and expressed remorse for the consequences of those errors, it was not satisfied that she had demonstrated a sufficiently developed level of insight into the causes of her misconduct, the risks posed to vulnerable patients, or the steps required to prevent a recurrence.

The panel recognised that the misconduct identified in this case is capable of remediation. The concerns relate to clinical practice, including patient identification, medicines management, adherence to nasogastric tube protocols and accurate record keeping. The panel considered that these are areas of practice which can be addressed through the development of insight, reflection, targeted training and a demonstrated commitment to safe practice. However, the panel had limited evidence of any completed training, reflective pieces evidencing meaningful insight, supervised practice, or other objective evidence demonstrating that she had strengthened her practice in the areas of concern or addressed the underlying causes of her misconduct. Furthermore, the panel noted that Mrs Ward had provided testimonials. However, none of those testimonials pertained to the matters relating to the conduct found proved.

In the absence of persuasive evidence of fully developed insight, remediation or strengthened practice, the panel concluded that the risk of repetition remains and that the forward-looking elements of limbs a – c of the *Grant* test are engaged. The panel therefore determined that a finding of current impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required. The panel considered that a well-informed member of the public would be concerned if a

finding of current impairment were not made in circumstances where a registered nurse who had committed serious patient safety failings had not yet demonstrated fully developed insight or sufficient remediation.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Ward's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Ward'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 18 months. The effect of this order is that the NMC register will show that Mrs Ward 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 regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that, in the Notice of Meeting, the NMC advised Mrs Ward that it would seek the imposition of a conditions of practice order if her fitness to practise were found to be currently impaired. The NMC submitted:

> *"41. We consider that the appropriate sanction is a 12-month conditions of practice order.*
> *42. The following factors are relevant:*
> ***Aggravating factors:***

• Conduct which deliberately or recklessly puts people receiving care at risk of suffering harm.

• Failure to attend hearings, or to engage in the Fitness to Practice process without good reason.

• Absence of or limited insight.

• Vulnerability to the person receiving care (for example being a child)

Mitigating:

• Early admissions in relation to some concerns

• No other regulatory concerns

43. With regard to our sanctions guidance the following aspects have led us to this conclusion:

44. ***Taking no further action (SAN2-a)*** *is only appropriate in exceptional circumstances. In most cases where impairment has been found a sanction will be required to secure public safety, uphold public confidence and maintain professional standards. There are no exceptional circumstances in this case and little or no remediation and insight, therefore taking no further action would not be appropriate in this case.*

45. ***Caution Order (SAN2-b)*** *is only appropriate where the panel has decided there is no risk to the public or to people using services that requires the professional's practice to be restricted. This is not a case at the lower end of the spectrum, nor has Mrs Ward provided sufficient evidence of retraining, reflection or insight to make repetition highly unlikely.*

46. ***Conditions of Practice Order (SAN2-c)*** *may be appropriate when any of the following factors are present:*

• no evidence of deep-seated personality or attitudinal problems

• identifiable areas of the professional's practice in need of assessment and/or retraining

• …

• …

• …

• people using services will not be put at risk either directly or indirectly as a result of the conditions

• conditions can be created that can be monitored and assessed.

47. The NMC note that the guidance invites the panel to consider whether the professional has shown "potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)". Mrs Ward has not provided any evidence to confirm she would be willing to engage in retraining. Nevertheless the NMC consider a conditions of practice order to be appropriate and proportionate in this case. Relevant, proportionate, workable and measurable conditions of practice could be formulated in this case.

48. ***Suspension Order*** *(SAN-2d) may be appropriate where:*

• the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional

• an outcome less severe than strike-off would still satisfy the over-arching objective.

49. The impairment in this case is serious in that the concerns have not been addressed, and therefore it is not highly unlikely that the behaviour will be repeated, however, the impairment is not fundamentally incompatible with continued registration.

50. In the circumstances of this case a suspension order would not be appropriate or proportionate. The charges are not at the most serious end of the spectrum and No actual patient harm occurred. Additionally, Mrs Ward demonstrated some insight into her actions.

51. ***Striking-off Order*** *(SAN-2e) would be disproportionate in this case as the concerns do not fall within the categories of cases most likely to result in a striking off order being imposed.*

52. The NMC consider that:

• The concerns do not raise fundamental questions about Mrs Ward's professionalism.

• Public confidence in the profession can be maintained without Mrs Ward's removal from the register.

• Mrs Ward could continue to develop her insight and reflection to keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards.

• There is a realistic prospect Mrs Ward will gain insight and strengthened their practice such that the risk they pose will have reduced."

Decision and reasons on sanction

Having found Mrs Ward's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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 regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- conduct which recklessly puts people receiving care at risk of suffering harm
- absence of or limited insight
- vulnerability of the patients receiving care

The panel also took into account the following mitigating features:

- early admission in respect of some of the concerns
- [PRIVATE]
- a challenging working environment

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.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that Mrs Ward's misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Mrs Ward practise would not protect the public. The panel also determined 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 Mrs Ward's registration would be appropriate. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel was satisfied that the concerns identified in this case are clinical, specific and remediable. The misconduct identified relates to identifiable and remediable areas of clinical practice, namely patient identification, medicines management, adherence to nasogastric tube protocols and accurate record keeping. The conduct does not involve deep-seated attitudinal concerns, dishonesty, deliberate harm or behaviour fundamentally incompatible with continued registration. The panel considered that these concerns are capable of being addressed through retraining, supervision and reflection.

Whilst Mrs Ward is not currently practising and has indicated that she does not presently intend to return to nursing. The panel noted that Mrs Ward remains a registered nurse and that her stated intentions may change during the currency of any order. The panel considered that it must impose the least restrictive sanction capable of addressing the risks identified and meeting the overarching objectives of the NMC.

The panel acknowledged that Mrs Ward is not currently practising. However, the panel was satisfied that the conditions are capable of being complied with should Mrs Ward decide to return to nursing practice during the period of the order. The panel considered that the conditions would provide an appropriate framework for supervision, support and remediation and would ensure that any return to practice takes place with adequate safeguards in place.

The panel was satisfied that workable, measurable and proportionate conditions can be formulated to address the concerns identified and to protect the public. The panel considered that, should Mrs Ward choose to return to practice, the conditions would provide an appropriate framework for supervision, support and remediation.

The panel considered whether Mrs Ward's stated intention not to return to practice rendered a conditions of practice order unworkable. It concluded that it did not. The order remains workable because its requirements are activated only if and when Mrs Ward resumes nursing practice.

The panel next considered a suspension or a striking off order. The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case. The panel considered whether a suspension order would be appropriate. It had regard to the NMC Guidance on Suspension order and noted that suspension is likely to be appropriate where there are serious concerns that cannot be addressed by a conditions of practice order, where there is evidence of deep-seated attitudinal problems, or where the misconduct is fundamentally incompatible with continued registration. The panel determined that those factors are not present in this case. The misconduct, whilst serious, relates to identifiable and remediable areas of clinical practice. There is no evidence of deep-seated attitudinal concerns, dishonesty, deliberate harm, abuse of trust, or persistent failure to address concerns.

The panel also considered a striking-off order and had regard to the NMC Guidance on Striking-off order. The panel determined that the nature and gravity of the misconduct did not justify permanent removal from the register. The concerns are capable of remediation and are not fundamentally incompatible with continued registration.

In all the circumstances, the panel concluded that a conditions of practice order is the least restrictive sanction capable of protecting the public, will mark the importance of maintaining public confidence in the profession and upholding proper professional standards 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 a more restrictive sanction, such as suspension, would be disproportionate.

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 limit your nursing practice to one substantive employer which must not be via an agency.

2. You must ensure that you are supervised by another registered nurse any time you are working. Your supervision must consist of:
   a) Working at all times on the same shift as, but not always directly observed by, another registered nurse.
   b) Monthly meetings with your line manager supervisor or mentor to discuss the following aspects of your clinical practice:
      i. Medications management and administration
      ii. Record keeping

3. You must be directly observed by another registered nurse at any time that you are managing and administering medication.

4. Prior to returning to paediatric nursing practice, you must complete nasogastric (NG) tube insertion and management training. Any management and/or insertions of NG tubes must be carried out

under direct supervision until you have successfully completed a competency assessment and been deemed competent by a registered nurse.

5. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from your line manager, mentor or supervisor. The report will comment on:
   a) Record keeping
   b) Medications management and administration
   c) If working in paediatrics, management and insertions of NG tubes

6. 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.

7. 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.

8. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any employers you apply to for work (at the time of application).
   c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

9. 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.

10. 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 18 months. The panel considered this period is sufficient to protect the public and maintain confidence in the profession whilst providing Mrs Ward with an opportunity to develop her insight, undertake relevant training and reflection, and address the concerns identified should she decide to return to practice. The panel further considered that, given the length of time Mrs Ward has been out of practice, she may need to undertake return to practice requirements before resuming nursing. The panel was satisfied that a period of 18 months would provide sufficient time for Mrs Ward to comply with any such requirements and demonstrate strengthened practice.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mrs Ward 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 strengthened practice including any relevant training undertaken by Mrs Ward in respect of the matters found proved
- An up-to-date reflective piece evidencing developed insight into concerns

- Up-to-date information from Mrs Ward with regard to her future nursing intentions

This will be confirmed to Mrs Ward in writing.

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 Mrs Ward'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 which stated:

> *"53. If a finding is made that Mrs Ward's fitness to practise is impaired on a public protection and public interest basis and a conditions of practice order imposed, the NMC invites the panel to impose an 18 month interim suspension order to be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest. This is because any sanction imposed by the panel would not come into immediate effect but only after the expiry of approximately 28 days after the sending of the decision letter or after any appeal is resolved. If an interim order were not imposed and Mrs Ward lodged an appeal, she would be able to practise unrestricted until the conclusion of the appeal."*

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 Mrs Ward is sent the decision of this hearing in writing.

That concludes this determination.