Northern Ireland Social Care Council

Notice of Decision of the Northern Ireland Social Care Council's Conduct Committee (Health Procedure)

REDACTED

Name: **Maria Jane Conner**

SCR No: **6005528**

NOTICE IS HEREBY GIVEN THAT the Conduct Committee of the Northern Ireland Social Care Council, at its meeting on **12 March 2015**, made the following decision about your registration with the Northern Ireland Social Care Council:

The Committee found the facts proved;

The Committee found that you have committed misconduct;

The Committee decided to admonish you and directed that a record of the admonishment should be placed on your entry in the Register for a period of four years.

Charge:

That, being registered under the Health and Personal Social Services Act (Northern Ireland) 2001 (as amended), and while working as a senior care worker at De La Cour House (Clanmil Housing Association):

1.	On or about 20 December 2012, you failed to record on the medication administration record that you had administered medication to Resident A.
2.	On or about 31 December 2012, you failed to update Resident's A main prescription sheet in relation to a new prescription.
3.	On or about 07 January 2013, you failed to record the administration of vitamins to Resident C on the medication administration record.
4.	On or about 07 January 2013, you signed the medication administration record to indicate the administration of medication which had in fact been refused by Resident D.
5.	On or about 16 January 2013, you administered the wrong medication to Resident B.
6.	On or about 17 January 2013, you recorded an incorrect dose of medication on the main prescription sheet for Resident A.
7.	On or about 16 February 2013, you omitted to record the dose of Pravastin administered to Resident A on

	their main prescription sheet.
8.	On or about 04 March 2013, you administered an incorrect dose of Atorvastatin to Resident B.
9.	On or about 04 March 2013, you failed to record on the medication administration record medication administered to Resident G.
10.	On or about 08 March 2013 and / or 09 March 2013, you recorded on Resident G's medication administration record that you had administered medication which you had not administered.
11.	On or about 09 March 2013, you recorded on Resident H's medication administration record the incorrect date for administration of medication.

And your actions as set out above amount to misconduct, such as to call into question your suitability to remain on the Social Care Register.

Preliminary Matters

The Registrant attended the hearing and was represented by Mr Dennis Hamill. The Northern Ireland Social Care Council (NISCC) was represented by Mr Conrad Dixon.

Background

The Registrant is registered on Part 2 of the Social Care Register (Social Care Worker), and has been from 24 January 2013. The Registrant was employed as a Senior Care Assistant (SCA) with Clanmill Housing at De La Cour House (the Home) from 05 August 2012 until her employment was terminated during her probationary period on 08 April 2013 for reasons connected to the allegations before this Committee. De La Cour House provides residential housing for people who are elderly and / or have dementia. At the time the Registrant worked in the Home, there were 13 residents who required 24 hour care. Senior Care Assistants at the Home have specific responsibility for residents' medication and the keeping of records in relation to same. The shift patterns at the Home are structured so that there is always one SCA or Assistant / Acting SCA on duty.

One of the duties that each SCA has in a shift is to do a count of the residents' medication and compare it with the residents' records to ensure that the records have been maintained accurately and to ensure that each resident has received the medication they are supposed to. The allegations in the Charge relate to medication errors made by the Registrant between 20 December 2012 and 09 March 2013 as set out above. Throughout this time period, the Registrant was in the probationary period of her employment.

The first error was reported by Geraldine Massey, a SCA, to the Home Manager, Maureen Corry. Other members of staff at the Home, Pauline Toner, Acting SCA, Danielle Dawson, SCA and Jill Kirk, Care Assistant and Acting Senior Care Assistant, became aware of subsequent medication errors made by the Registrant and reported them to Maureen Corry.

Due to the amount of medication errors made by the Registrant during this time, Maureen Corry called the Registrant to an investigation meeting on 19 March 2013, with a view to instituting disciplinary proceedings. Following this meeting, Maureen Corry completed an Investigation Report. In this Report, Ms Corry details the amount of training that the Registrant had received, to include additional training she was given after problems with medication administration in October 2012. After considering the amount of errors made, the seriousness of the errors and the training that the Registrant had already been given on more than one occasion, Ms Corry recommended that the Registrant should not be confirmed in post.

A Probationary Hearing was then held on 08 April 2013, which the Registrant attended. At this Hearing, the Registrant largely accepted that she had made the errors, although she could not specifically remember some of the specific incidents. The Registrant also mentioned that she had been off work with [REDACTED] for seven weeks during this time. The Registrant also stated that she was not used to working in a role where she was required to give out so much medication, and that this had affected both her [REDACTED] and her confidence. The Registrant referred to other matters that she had reported during her time in the Home, and said that she hoped the investigation into her was not motivated by revenge. Following this meeting, a decision was made to terminate the Registrant's employment and this was confirmed in writing to her.

The matter was then referred to the NISCC on 18 April 2013.

Application to Admit Hearing Bundle

Mr Dixon made an application, pursuant to Paragraph 11 of Schedule 2 of the 2014 Conduct Rules (the Rules), to admit a bundle of documents. He indicated that the bundle had been served on the Registrant and contained five witness statements with related exhibits, the minutes of the investigation meeting, Ms Corry's Investigation Report and the minutes from the Probationary Hearing. The bundle also included a medical report from [NAME REDACTED] following an interview with the Registrant on 14 January 2015. In his report, [NAME REDACTED] detailed that he had sight of the Registrant's GP notes and records, the Charges faced by the Registrant, a copy of the 2014 Rules and had spoken to a cousin of the Registrant before preparing the report. Mr Hamill, on behalf of the Registrant, indicated that he had no objection to the admission of the documents within the hearing bundle. Accordingly, the Committee received the bundle into evidence.

Findings of Fact

At the outset of the hearing, Mr Hamill, on behalf of the Registrant, informed the Committee that the Registrant admitted all of the facts and accepted that those facts amounted to misconduct. The Committee received an agreed Statement of Facts, signed by the Registrant's solicitor and dated 12 March 2015, as follows:

1. The Registrant was employed as a Senior Care Assistant with Clanmil Housing Association from 05 August 2012. The Registrant was dismissed from her employment on 08 April 2013. The Registrant was based at De La Cour House.

2. De La Cour House provides residential housing for people who are elderly and/or have dementia. When the Registrant worked at the Home there were 13 residents who required 24 hour care.

3. The Registrant was registered on Part 2 of the NISCC Register on 24 January 2013.

4. The shift patterns in De La Cour House are structured so that there is always one Senior Care Assistant or Acting Senior Care Assistant on duty. The Senior Care Assistant is responsible for the administration and recording of medication.

5. During the Registrant's employment as a Senior Care Assistant at De La Cour House, she made repeated errors in relation to the administration of medication. The Registrant made the following errors:

   (i) On or about 20 December 2012, the Registrant failed to record on the medication administration record that she had administered medication to Resident A;

   On 20 December 2012, the Registrant was the Senior Care Assistant on shift. One of the duties of the Senior Care Assistant is to count each resident's medication and compare it with the resident's records to ensure that the records are accurately maintained and that each resident has received the correct medication.

   On 20 December 2012, the Registrant administered several medications to Resident A but did not record this on their medication administration record.

   (ii) On or about 31 December 2012, the Registrant failed to update Resident A's main prescription sheet in relation to a new prescription.

   On 31 December 2012, Resident A was discharged from hospital with an instruction that he should commence Lactulose. When a resident's medication is changed upon their discharge from hospital, the Senior Care Assistant on shift is required to update the main prescription sheet to ensure the resident receives the new medication as directed.

   On 31 December 2012, the Registrant was the Senior Care Assistant on shift and it was her responsibility to update Resident A's prescription sheet on his discharge from hospital. The Registrant failed to do this. The error was noticed by another member of staff who came on duty later the same day.

   (iii) On or about 07 January 2013, the Registrant failed to record the administration of vitamins to Resident C on the medication administration record.

   On 07 January 2013, the Registrant administered vitamins to Resident C. When vitamins are administered to a resident these are signed on the resident's medication administration record. The Registrant administered vitamins to Resident C on 07 January 2013 and failed to record this on their medication administration record. On 08 January 2013, another Care Assistant noted that there was a discrepancy. The error was highlighted to the Registrant and she confirmed that she had failed to record the administration of vitamins to Resident C.

(iv) On or about 07 January 2013, the Registrant signed the medication administration records to indicate the administration of medication which had in fact been refused by Resident D.

On 07 January 2013, the Registrant completed the medication record sheet to indicate that she had administered Calcichew to Resident D. Resident D had refused the Calcichew medication and the Registrant's record was not accurate. The medication administration record should only be signed when the correct dose of medication has been seen to be taken by the resident.

(v) On or about 16 January 2013, the Registrant administered the wrong medication to Resident B.

On 16 January 2013, the Registrant gave two paracetamol tablets to Resident B that belonged to another resident (Resident E).

(vi) On or about 17 January 2013, the Registrant recorded an incorrect dose of medication on the main prescription sheet for Resident A.

The Registrant was on duty as a Senior Care Assistant on 17 January 2013. Instructions had been received from Resident A's GP that he should commence Epilim at a dose of 500mg twice a day instead of 300mg twice a day. The Registrant updated Resident A's main prescription sheet to reflect the medication change. The Registrant erroneously doubled the dose and recorded that Resident A should receive two 500mg tablets twice a day.

(vii) On or about 16 February 2013, the Registrant omitted to record the dose of Pravastin administered to Resident A on their main prescription sheet.

The Registrant was the Senior Care Assistant on duty during the shift. On 16 February 2013, the Registrant rewrote the medication prescription sheet for Resident A. The Registrant omitted the dose of Pravastin Resident A was prescribed. This was later corrected by a colleague.

(viii) On or about 04 March 2013, the Registrant administered an incorrect dose of Atorvastatin to Resident B.

On 04 March 2013, the Registrant administered two doses of Atorvastatin to Resident B. Resident B was only to receive one dose.

(ix) On or about 04 March 2013, the Registrant failed to record on the medication administration record medication administered to Resident G.

On 04 March 2013, the Registrant administered Natecal and Hepa-Merz to Resident G but did not record this in Resident G's medication administration record.

(x) The Registrant, on or about 08 March 2013 and / or 09 March 2013, recorded on Resident G's medication administration record that she had administered medication which she had not administered.

On 09 March 2013, the Registrant recorded that she had administered Natecal at 15:00 hours on 08 March 2013 and at 08:30 hours on 09 March 2013 to Resident G. This was an error as the Registrant had not administered either of these medications.

(xi) On or about 09 March 2013, the Registrant recorded on Resident H's medication administration record the incorrect date for administration of medication.

The Registrant had signed Resident H's medication administration record to suggest that she had administered tablets to Resident H at 8.00 pm on 09 March 2013. The Registrant was not on duty at 8.00 pm on 09 March 2013 and her record was inaccurate.

Mr Dixon read the agreed statement to the Committee and Mr Hamill confirmed that its contents were agreed by Ms Conner. The Committee retired and examined the hearing bundle and the agreed Statement of Facts. In approaching the task of determining the factual particulars, the Committee has kept at the forefront of its deliberations the importance of requiring the NISCC to prove matters against the Registrant. The Registrant herself is not required to prove anything. The standard of proof to which the NISCC is required to prove matters is the civil standard, on the balance of probabilities.

Following its examination of the bundle, the Committee announced that the agreed Statement of Facts was approved, and announced the facts at numbers 1 to 11 in the Charge proved by admission.

The evidence of the five witnesses who provided statements for the NISCC investigation had been agreed between the Parties in advance of the hearing. None of these witnesses were therefore called to give oral evidence.

Misconduct

Having found the facts proved in the Charge, the Committee proceeded to consider the issue of misconduct. Before reaching its decision, the Committee had regard to the submissions made on behalf of the Council by Mr Dixon and the medical evidence produced.

Mr Dixon referred the Committee to the NISCC Code of Practice for Social Care Workers and submitted that the Registrant's behaviour breached the Code at Code 5, specifically 5.1 and 5.7. He submitted that Code 6, specifically 6.1, 6.2, 6.3 and 6.4 were also breached. He submitted that the errors made by the Registrant amounted to a serious departure from the standards to be expected of a senior care worker. He referred the Committee to the amount of training that the Registrant had received in relation to the administration of medication. He stated that the Registrant was in a position of responsibility but that many of the medication errors were at a basic level. Mr Dixon invited the Committee to consider the period of time over which the errors had occurred and their repeated nature. Mr Dixon referred to the reference to the examination of the Registrant's GP notes and records in the report of [NAME REDACTED]. The Registrant was noted to have felt strong enough to return to work on 03 December 2012 but that very shortly after she did, the medication errors started. He stated that this may in itself have been a breach of the Code as the Registrant is under a duty to ensure that she was fit to return and to administer medication.

Mr Hamill did not make any specific submissions in relation to misconduct, save to repeat that the Registrant accepted that the admitted facts amounted to misconduct. He did advise the Committee that the Registrant reserved the right to address the Committee at the mitigation stage.

The Committee then received the advice of the Medical Adviser. He advised the Committee that he concurred with the conclusion of [NAME REDACTED] when he stated '[REDACTED]' and when he stated, 'I am satisfied that her ill health would have substantially contributed to the alleged misconduct'. The Medical Adviser advised the Committee that the report was written following a consultation with the Registrant and a review of her GP notes and records. The Medical Adviser stated that the medication history within the report would indicate that the patient was [REDACTED] during the period relevant to the Charges. The Medical Adviser advised the Committee that, in his opinion, the Registrant's misconduct may have been caused, or substantially contributed to, by the Registrant's ill health.

The Committee also heard and accepted the advice of the Legal Adviser.

The Committee reminded itself that misconduct is defined in the Rules as *'conduct which calls into question the Registrant's suitability to remain on the Register'*. The Committee also derived assistance from the definition of misconduct recited in *Roylance v GMC (No.2) [2000] 1 AC 311 at 330*. In that case, the Privy Council said that *'misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances...it is not any professional misconduct which would qualify. The professional misconduct must be serious.'*

The Committee reminded itself of the requirements of Paragraph 12 (1) of Schedule 2 of the Rules. The Council has brought these proceedings against the Registrant. The burden rests upon the NISCC to prove that the Registrant has acted in a manner which amounts to misconduct.

The Committee gave careful consideration to the submissions, the medical evidence adduced and the medical and legal advice it received. The Committee finds that the Registrant's actions, as set out in the Charge, were in breach of the following provisions of the NISCC Code of Practice for Social Care Workers, and they amounted to misconduct:

Code 5: As a social care worker, you must uphold public trust and confidence in social care services. In particular you must not:

5.1 Abuse, neglect or harm service users, carers or colleagues; or

5.7 Put yourself or other people at unnecessary risk.

Code 6: As a social care worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills. This includes:

6.1 Meeting relevant standards of practice and working in a lawful, safe and effective way; and

6.2 Maintaining clear and accurate records as required by procedures established for your work.

The Committee did not find that the Registrant had breached the Code at sections 6.3 or 6.4. It is not clear whether, or indeed to what extent, the Registrant informed her employer of her medical conditions and the Committee notes that the burden is on the NISCC to show that her behaviour, in this regard, amounted to misconduct. The evidence within the bundle suggests that the Registrant did ask for further training, therefore the Committee is not satisfied that section 6.4 has been breached.

The medication errors made by the Registrant were basic, and were repeated and serious. They involved the provision and recording of medication to elderly patients and there was a real potential that they could cause harm to patients. The errors made by the Registrant also had the potential to put her colleagues at risk, as they were dependent on her recording of medication to be accurate when administering medications themselves. The Committee noted the Registrant's position in the bundle that she had not previously worked in a role where she was required to administer as much medication, but was conscious that she had received training, and indeed retraining, in relation to the administration of medication. The Committee has no doubt that the Registrant's errors amounted to serious misconduct.

The Committee considered whether the misconduct, now found, may have been caused, or substantially contributed to, by the Registrant's physical or mental ill health. The Committee considered the medical report of [NAME REDACTED] and the advice of the Medical Adviser.

The Committee noted the comments made by [NAME REDACTED] when he stated:

'[REDACTED]'.

It seems clear to the Committee that the Registrant's health issues were a significant factor in the Registrant's misconduct. [REDACTED] and the report makes it clear that these persisted at the time the medication errors were made. The Committee also notes the letter from the Registrant's GP dated 09 January 2015, wherein she makes it clear that the Registrant remains under treatment [REDACTED]. The advice of the Medical Adviser is that he fully concurs with the opinion of [NAME REDACTED]. In summary, the Committee agrees with the conclusion of [NAME REDACTED] when he states:

'From her description of her symptoms at the time and from the GP records I am satisfied that her ill health would have substantially contributed to the [Registrant's] misconduct' and the Committee so finds accordingly.

Sanction

Mr Dixon advised the Committee that the Registrant had no previous record with the Council. The Registrant then gave oral evidence to the Committee. She stated that she deeply regretted her actions and did not seek to distance herself from the errors. She explained that she had previously not worked in a role like that in the Home and that the medication regime in Scotland, where she had previously worked, was very different from that in Northern Ireland. She accepted that, with hindsight, she probably was not fit to return to work when she did. The Registrant stated that after she lost her job with the Home, she returned to work in social care as a senior support worker in Scotland. During this time, she underwent a course in medication administration and produced a guide

to the administration of medicines for her employer. She expressed a desire to return to work as a social care worker and stated that she would apply what she has learnt since her errors in the future.

Mr Dixon addressed the Committee on the issue of sanction and invited the Committee to treat the failures of the Registrant as very serious. Mr Hamill asked the Committee to give the Registrant maximum credit for her early admissions and to the insight that she now displays. He also asked the Committee to take into account that the Registrant has already been suspended for a significant time following the imposition of an Interim Suspension Order, but that during that time she has attempted to keep up to date with social care work.

In deciding which sanction to impose, the Committee has taken into account:

a. the seriousness of the Registrant's misconduct;

b. the protection of the public;

c. the public interest in maintaining confidence in social care services;

d. the issue of proportionality.

Paragraph 25 of Schedule 2 of the Rules provides that, upon a finding of misconduct, the Committee may:

a. admonish the Registrant and direct that a record of the admonishment should be placed on the Registrant's entry in the Register for a period of up to 5 years; or

b. make an Order suspending the Registrant's registration for a period not exceeding two years (a 'Suspension Order'); or

c. make an Order for removal of the Registrant's registration from the Register ('a Removal Order');

The Committee is mindful that the purpose of sanctions is not punitive. Sanctions are imposed to the extent it is necessary to protect the public. The other relevant considerations include maintaining public confidence in the profession concerned, maintaining confidence in the NISCC regulatory process and the deterrent effect on other registrants. In order to ensure that no more severe sanction is imposed than is required, the Committee considered the available sanctions in Paragraph 25 of Schedule 2 in ascending order of gravity.

In addition, during its considerations, the Committee had regard to the principle of proportionality and the need to strike a balance between the interests of the public and the rights of the Registrant. The Committee has given due consideration to the NISCC Indicative Sanctions Guidance, and has accepted the advice of the Legal Adviser and the Medical Adviser.

As it is obliged to under Paragraph 28 (3) of the Rules, the Committee considered the medical evidence, and whether the misconduct may have been caused, or substantially contributed to, by the Registrant's physical or mental ill health.

The Committee examined the factors contained in the Indicative Sanctions Guidance, and gave full and detailed consideration to the relevant factors detailed therein in the context of all of the information presented, before reaching the following conclusions:

Admonishment – taking all of the evidence into account, the Committee concluded that admonishment was the appropriate and proportionate sanction in this case. The Committee would first make it clear that the misconduct found was serious, it did have the potential to cause direct harm to service users and it was not isolated. The Committee did consider the Guidance, but finds, in the particular circumstances of this case, that an admonishment is both appropriate and proportionate.

The Committee would first state that it found the Registrant's expression of remorse and regret to be genuine. She now appears to fully understand the implications of her medication errors. The Committee has made a finding that the Registrant's misconduct, at the time, was caused, or substantially contributed to, by her ill health. The Registrant has given clear and cogent evidence that she was not aware of the impact of her health on her ability to safely administer medication at the time of the errors she made. The Committee notes that the Registrant remains unwell, and indeed now has [REDACTED]. The Committee is impressed, however, by the level of insight that the Registrant displays in relation to her health. She is receiving apparently appropriate care and has attended [REDACTED]. She told the Committee that if she found herself in a similar position in future, she would immediately inform her superiors that she was feeling [REDACTED]. The Committee notes that the Registrant now talks openly with colleagues and professionals about her health condition, which evidences her preparedness to seek help on an on-going basis. This further reassures the Committee that the Registrant has taken rehabilitative steps and that there is limited likelihood of repetition of the misconduct.

The Committee was impressed by her evidence of her good relationship with her GP. She told the Committee that she can share anything with her, and this further encourages the Committee that she is aware of her problems but is striving to deal with them. The Committee was impressed and believes the Registrant's stated passion to return to social care work. She has, since these incidents, undertaken further education to include a course specifically designed to deal with the administration of medications, both in giving them to patients and the recording of same. This shows her willingness to take remedial action to address her deficits.

The Committee was also impressed with the Registrant's references and testimonials. These present the Registrant as a person suited to a role in social care work, and as someone who is always prepared to go the extra mile to help those in need. These testimonials refer to her ability to share her difficulties with others, which is further evidence of her insight into her health conditions. These references support the Registrant's evidence to the Committee that she has learnt from this experience. The Committee finds that she has taken real steps to remedy her failings, is more aware of the effect of [REDACTED] upon her and that this, therefore, makes repetition of this misconduct unlikely. The Committee is satisfied that this sanction will afford the necessary degree of public protection and will, in the circumstances of this case, uphold public confidence in the regulatory system.

The Committee then considered the period of admonishment that should be applied in this case. The Committee has taken into account the advice contained within the Indicative Sanctions Guidance that a period of three years should be used as the benchmark for an admonishment, and this period should only be increased or decreased if

the particular facts of the case make it appropriate to do so. The Committee finds that this is such a case, given the seriousness of the medication errors. The Committee did reconsider the mitigating factors present, but finds that a period of admonishment of four years is appropriate and proportionate in this case in order to mark the seriousness of the failings and to ensure public confidence in the regulatory process is maintained.

The Interim Suspension Order currently in place is hereby revoked.

Legal Advice Given

Finding of Facts

The facts have been admitted and, under the Rules, you will be allowed to announce that they have been proven by admission. However, Paragraph 18 (4) does require the Committee to approve the agreed Statement of Facts and you can only meaningfully do that having read the bundle. The Committee will obviously have to read the bundle at some stage today in relation to all of the matters it has to consider, so my advice would be that the Committee retires now to read the bundle and decide whether or not it wishes to approve the Statement of Facts and then announce its decision on the facts.

All of that being caveated by the fact that the Registrant has admitted the facts.

Misconduct

It will be clear from your reading of the bundle, which you have just examined, that you are dealing largely with matters that display a lack of competence on the part of the Registrant. However, it is a settled legal precedent that a lack of competence on behalf of a Registrant is capable of amounting to misconduct, because a lack of competence can properly be regarded as a serious departure from what would reasonably be expected from a practitioner employed to perform the tasks which the Registrant was employed to perform. You will also be aware of the definition of misconduct given in the Rules of this body, when it is described as 'conduct which calls into question the suitability of the Registrant to remain on the Register'.

The Courts have given some further guidance, most noted in the case of Roylance, and they describe misconduct as 'a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances'. Bear in mind that not all misconduct will qualify, the professional misconduct must be serious. The Courts advise you to refer to the relevant rules and standards ordinarily required to be followed by a practitioner in the particular circumstances, and here those are the Code of Practice for Social Care Workers, 2002.

You will also be aware that Paragraph 28 (3) of the 2014 Rules requires you to consider, in determining misconduct, any medical reports or other medical evidence on whether the alleged misconduct may have been caused, or substantially contributed to, by the Registrant's physical or mental ill health. Here you have seen the report of [NAME REDACTED] and have had the benefit of the advice of the Medical Adviser. You must consider that evidence and advice, along with everything else that you have heard today, and also your examination of the

bundle.

Misconduct is a matter on which you bring your professional judgment to bear. You are not bound by any standard or burden of proof.

Apart from advising the Committee that it must retire to consider this, despite the early admission by the Registrant that she feels it amounts to misconduct, it still remains a decision for the Committee. So the Committee will now retire and will make its decision. It will do so, and will write up reasons for that decision, and will then announce those reasons to the Parties.

Sanction

You have obviously heard submissions from Mr Dixon and Mr Hamill and you should give them full consideration in your deliberations on this.

You have also been referred to the NISCC Indicative Sanctions Guidance and I do commend that document to you with the one proviso: that it is a guide, and a guide only.

You must bear in mind that the purpose of any sanction is not to be punitive. The primary function, rather, is to address public safety from the perspective of the risk which the Registrant may pose to those who use or need her services. In reaching your decision, you must also give appropriate weight to the wider public interest and that includes the deterrent effect to other Registrants, the reputation of the profession, and the public confidence in this regulatory process.

Importantly, the Rules under the Health Procedure require you at this stage to again consider whether the alleged misconduct may have been caused, or substantially contributed to, by the Registrant's physical or mental ill health. You made a finding on that but you are obliged to revisit that finding at this stage of the proceedings.

You must also apply the principle of proportionality at all times, and that requires you to balance the interests of the public with those of the Registrant. You must also begin your consideration of sanction with the least severe and give full and detailed reasons for your decision.

Medical Advice Given

Misconduct

[REDACTED]

Medication

[REDACTED]

You have the right to appeal this decision to the Care Tribunal. Any appeal must be lodged in writing within 28 days from the date of this Notice of Decision.

You should note that the Conduct Committee's decision takes effect from the date upon which it was made.

The effect of this decision is that you have been admonished and a record of the admonishment will be placed on your entry in the Register for a period of four years. This admonishment does not affect your ability to work in social care.

Nelissa Cw — 19 March 2015

Clerk to the Conduct Committee — Date