Name of Registrant Nurse: Rebecca Zoe Thistle
NMC PIN: 12B0393E
Part(s) of the register: Registered Nurse (sub part 1) Adult
Area of registered address: North Yorkshire
Type of case: Misconduct
Panel members: Colin Youngson (chair, lay member)
Frances Clarke (registrant member)
Cynthia Mendelsohn (lay member)
Legal Assessor: Nigel Mitchell
Panel Secretary: Sam Hughes
Nursing and Midwifery Council: Represented by Daniel O'Donoughue, Case Presenter, Counsel, NMC Regulatory Legal Team
The registrant: Ms Thistle did not attend and was not represented
Facts proved: 1, 2, 3, 4, 5 and 7
Facts not proved: 6
Fitness to practise: Impaired
Sanction: Striking-off order
Interim order: Interim suspension order – 18 months
Service

Ms Thistle is neither present nor represented. The panel proceeded to determine whether the notice of hearing was served on Ms Thistle in accordance with the Nursing and Midwifery Council Fitness to Practise Rules 2004. The notice was sent to Ms Thistle’s address on the Register on 6 September 2016 by first class post and recorded delivery.

The panel is satisfied that proper service has been effected in accordance with Rules 11 and 34 of the Nursing and Midwifery Council Fitness to Practise Rules 2004.

Proceeding in the absence of Ms Thistle

The panel then turned to the question of whether to proceed in Ms Thistle’s absence pursuant to Rule 21(2):

Where the registrant fails to attend and is not represented at the hearing, the committee:

a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these rules to serve the notice of hearing on the registrant;

b) may, where the committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant or;

c) may adjourn the hearing and issue directions.

The panel heard the representations made by Mr O’Donoughue on behalf of the NMC that it was appropriate to proceed in the absence of Ms Thistle. He informed the panel that Ms Thistle has not engaged whatsoever in these proceedings despite various written communication to her. The panel heard that the NMC further attempted to contact Ms Thistle by telephone on 7 October 2016 to establish whether she intended to attend this hearing. However, the panel heard that Ms Thistle terminated the call when the case officer stated that they were phoning from the NMC. Mr O’Donoughue further
submitted that it was in the public interest to proceed with this hearing and that six witnesses were due to attend.

The panel accepted the advice of the legal assessor. The panel accepted that its duty was to exercise the utmost care and caution in deciding whether or not to proceed in Ms Thistle’s absence. The panel weighed any disadvantage to Ms Thistle in not being present against the public interest in hearing these matters expeditiously.

In all the circumstances, and balancing the factors set out above, the panel has decided that it is fair, in the public interest and in the interests of justice to proceed in her absence.

**Charges**

That you, a registered nurse:

1. On 13 December 2014, instructed a care assistant to administer an inhaler to Resident C when the administration required a registered nurse or a senior carer;

2. On 14 December 2014:
   2.1. Did not ensure that any and/or all of Resident D’s medication was properly administered;
   2.2. Incorrectly signed to indicate that Resident D’s medication had been properly administered;

3. On 1 May 2015:
   3.1. Did not contemporaneously record that you administered Mirtazapine to Resident G at 17.00;
   3.2. Did not handover that Resident G had received Mirtazapine at 17.00;

4. On or after 2 May 2015:
   4.1. Did not document that Resident G had received an additional dose of Mirtazapine on 1 May 2015;
4.2. Did not escalate that Resident G had received an additional dose of Mirtazapine on 1 May 2015;
4.3. Changed Resident G’s drug administration time in respect of Mirtazapine from 22:00 to 17:00 without consulting Resident G’s doctor and/or without clinical justification;
4.4. Retrospectively amended Resident G’s medication administration record to record the administration of Mirtazapine at 17:00 on 1 May 2016

5. On 12 May 2015:

5.1. Did not administer the following medication to Resident H at 08:00:
   5.1.1. 20mg Omeprazole;
   5.1.2. 75mg Clopidogrel;
   5.1.3. 40mg Furosemide;
   5.1.4. 100mcg Levothyroxine;

5.2. Incorrectly recorded that you had administered the following medication to Resident H at 08:00:
   5.2.1. 20mg Omeprazole;
   5.2.2. 75mg Clopidogrel;
   5.2.3. 40mg Furosemide;
   5.2.4. 100mcg Levothyroxine;

5.3. Did not administer 20mg Omeprazole to Resident H at 17:00 and/or record the reason for not administering the medication;

5.4. Did not administer the following medication to Resident I:-
   5.4.1. 75mg Aspirin at 08:00;
   5.4.2. 20mg Omeprazole at 08:00;
   5.4.3. 30mg Mirtazapine at 17:00;
   5.4.4. 200mg Quinine Sulphate at 17:00;

5.5. Incorrectly recorded that you had administered the following medication to Resident I:
5.5.1. 75mg Aspirin at 08:00;
5.5.2. 20mg Omeprazole at 08:00;
5.5.3. 30mg Mirtazapine at 17:00;
5.5.4. 200mg Quinine Sulphate at 17:00;

5.6. Did not administer 100mg Co-careldopa to Resident B at 17:00;

5.7. Incorrectly recorded that you had administered 100mg Co-careldopa to Resident B at 17:00;

5.8. Did not administer a Calceos tablet to Resident J at 17:00;

5.9. Incorrectly recorded that you had administered a Calceos tablet to Resident J at 17:00;

6. Your conduct at any or all of charges 2.2 and/or 5.2 and/or 5.5 and/or 5.7 and/or 5.9 was dishonest in that you:
   6.1 knew that you had not administered the medication referred to;
   6.2 intended to create the impression that you had administered the medication

7. Your conduct at charge 4.3 above was dishonest in that you:
   7.1 knew that you did not have the authority to change the administration time;
   7.2 knew that the change was not clinically justified;
   7.3 intended to create the impression that the patient’s medication administration time had changed when that was not the case;
   7.4 intended to disguise the fact that administered the medication at the incorrect time on 1 May 2015

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

The panel considered all the oral and documentary evidence before it together with the submissions of Mr O’Donoughue on behalf of the NMC. It heard and accepted the advice of the legal assessor. The panel is aware that the burden of proof rests on the NMC to prove the facts alleged in relation to the charges on the balance of probabilities, meaning that the facts in the charges were more likely than not to have occurred. The panel considered each charge and sub-charge separately.

The panel heard oral evidence from six witnesses:

- Ms 1, Registered Nurse;
- Mr 2, Registered Nurse;
- Ms 3, HR Manager;
- Ms 4, formerly Manager at Oaklands Care Home (“the Home”);
- Ms 5, formerly a Care Assistant;
- Dr 6, GP.

The panel found that Ms 1 was a helpful and credible witness. She gave a consistent account. The panel noted that she appeared to be defensive of some of the Home’s former practices; however the panel was satisfied that her evidence was reliable.

The panel found that Mr 2 was also a helpful and credible witness. His recollection of the procedures in place at that time was not always particularly clear and he appeared to be defensive of some of the Home’s former practices; however the panel was satisfied that his evidence was reliable.

The panel found that Ms 3 was a helpful and credible witness. The panel found her to be thorough and well prepared. She had a good recollection of the events and the panel found her evidence to be reliable.

The panel found that Ms 4 was a credible witness. The panel noted that she maintained that Ms Thistle was a good nurse despite the allegations against her and therefore found her to be a balanced witness. She accepted that her interactions with Ms Thistle
were limited as she had not worked at the Home long before Ms Thistle was suspended.

The panel found that Ms 5 was a credible witness. She had a good recollection of the events and the panel found her evidence to be reliable.

The panel found that Dr 6 was also a credible witness. His recollection of the events at that time was not always particularly clear.

The panel was satisfied that there was no evidence of collusion between the witnesses. The witnesses were generally complimentary of Ms Thistle’s practice and the panel was of the view that they had no reason to collude and this had not been suggested by Ms Thistle at her investigatory meeting.

The panel heard that on 8 July 2013, Ms Thistle commenced employment at Maria Mallaband Care Group Ltd (“the Group”) as a nurse at the Home which provides residential and nursing care for the elderly.

On 18 December 2014, Ms Thistle was suspended pending a full investigation into various allegations relating to her practice by the Home. On 19 December 2014, Ms 3, HR manager at the Group, contacted Ms 5, a care assistant at the Home, and she raised a further allegation. Ms 5 alleged that, on 13 December 2014, Resident C needed her inhaler and Ms Thistle gave it to Ms 5 to give to Resident C. Ms 5 informed Ms Thistle that she could not give the inhaler to the resident as she was a care assistant and not authorised to do so. Ms Thistle is alleged to have put her coat on and gone outside. In addition, Ms 5 alleged that, on 14 December 2014 at approximately 10:00, she went to help Resident D to get dressed and she found six tablets that Ms Thistle should have administered to Resident D still on the resident’s bedside table.

On 28 April 2015, Resident G returned to the Home following a short period of admission to hospital. During his admission, it was decided that Resident G should have the time of his daily dose of the drug Mirtazapine changed to 22:00 because of its sedative effect. Upon Resident G’s return to the Home, he was provided with his dose of the drug at 22:00 each night as directed by the Medicine Administration Record
On 1 May 2015, Ms 1 went to administer Resident G’s medication as normal at 22:00. However, the medication pod for 1 May 2015, which was meant to contain Resident G’s medication, was empty. Ms 1 alleged that she had not been informed that Resident G had received his dose of medication earlier that day, and there was nothing on the MAR chart to suggest this. As such, Ms 1 continued to administer the medication to Resident G at 22:00 using medication from a medication pod that was left over following Resident G’s admission to hospital.

On 2 May 2015, at Ms 1’s handover of the care of Resident G to Ms Thistle, Ms Thistle is alleged to have informed her that she had also given Resident G a dose of his medication at 17:00 on 1 May 2015. Ms 1 was suspicious about this and photographed Resident G’s MAR chart which indicated that Resident G only received one dose of medication on 1 May 2015 which was administered by Ms 1 at the usual time of 22:00. On 5 May 2015, Ms 1 noticed that the time for Resident G’s drug administration had been changed from 22:00 to 17:00 and Ms Thistle’s signature had been inserted retrospectively for 1 May 2015 to say that she had administered medication to Resident G. Ms 1 took another photograph of Resident G’s MAR chart as evidence of the fact that it had been altered. On 13 May 2015, Ms 1 raised her concerns regarding Ms Thistle’s care of Resident G to Ms 4.

On 13 May 2015, Mr 2, a nurse at the Home, went to administer the teatime medication for Resident H, Resident I, Resident B and Resident J, all of whom had dementia. Mr 2 found on their respective MAR charts that Ms Thistle had signed that she had administered medication to them on 12 May 2015. However, Mr 2 noted that the medication for this administration was still in the pods. Mr 2 immediately raised this issue with Ms Thistle by phone and she said that she had administered the drugs.
Charge 1 – proved
On 13 December 2014, instructed a care assistant to administer an inhaler to Resident C when the administration required a registered nurse or a senior carer

Ms 5 told the panel that there were a number of residents that had dementia at the Home and were therefore unable to take their medication and required assistance or were to be watched as they took their medication. Ms 5 stated that this duty was only to be carried out by a registered nurse or senior carer such as Ms Thistle who had to sign the MAR chart to state that they had witnessed the resident take their medication. Ms 5 said that as she was a care assistant, she should not have provided a resident with their medication.

Ms 5 told the panel that Resident C needed her inhaler whilst Ms Thistle was on shift. Ms 5 further stated that Ms Thistle gave her the inhaler and told her to give it to the resident. However, Ms 5 stated that she was not sure how to use the inhaler herself so she asked Ms Thistle whether she should give it and asked her what she should do with it. Ms 5 stated that Ms Thistle responded that she should just give it to Resident C and proceeded to put her coat on and went outside. Ms 5 stated that she then handed over the inhaler to Resident C but Resident C was unable to administer it himself so she took it back. Ms 5 further stated that she then gave the inhaler to Ms Thistle when she came back inside the Home and explained to her that Resident C still needed it as she had been unable to administer it. Ms 5 concluded by stating that she is unsure what Ms Thistle did about this.

In light of Ms 5’s consistent and clear oral evidence and the supporting documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle instructed a care assistant to administer an inhaler to Resident C when the Home’s policy required that it be a registered nurse or a senior carer. The panel therefore finds charge 1 proved.
Charge 2 – proved

On 14 December 2014:

2.1 Did not ensure that any and/or all of Resident D’s medication was properly administered

2.2 Incorrectly signed to indicate that Resident D’s medication had been properly administered

Ms 4 told the panel that Ms Thistle was the only full time nurse at the Home and took on a number of duties which would fall upon a lead nurse, therefore Ms Thistle had the most input into the care provided at the Home. Ms 4 stated that Ms Thistle would make sure the residents’ medication was administered on time and checked into the Home correctly. Ms 4 stated that Ms Thistle would also supervise Health Care Assistants (“HCAs”). Medication could only be administered by a registered nurse or a senior carer. “Administer” means ensuring the medications are actually consumed by the resident.

Ms 5 told the panel that at approximately 10:00 on 14 December 2014, she went to help Resident D to get dressed when she found six of her tablets, which she was due to take with her breakfast that morning, but had not been taken. Ms 5 stated that Resident D was having some bad days and tended not to get up until lunch time. However, Ms 5 said that Ms Thistle should not have left the medication with Resident D and should have witnessed her take the medication and then signed the MAR chart to record this. Ms 5 told the panel that she mentioned to Ms Thistle that Resident D had not taken her tablets.

The panel had before it a copy of the relevant MAR chart. Ms 5 said that the MAR chart shows that Ms Thistle signed to state that she had administered Resident D’s medication on 14 December 2014, which she had not.

In light of Ms 5’s consistent and clear oral evidence and the supporting documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle did not ensure that any or all of Resident D’s medication was properly administered. The panel is also of the view that it is more likely than not that Ms Thistle incorrectly signed the
MAR chart to indicate that Resident D’s medication had been properly administered. The panel therefore finds charge 2 proved in its entirety.

Charge 3 – proved
On 1 May 2015:

3.1 Did not contemporaneously record that you administered Mirtazapine to Resident G at 17.00
3.2 Did not handover that Resident G had received Mirtazapine at 17.00

Ms 1 told the panel that on 28 April 2015, Resident G was discharged from hospital and returned to the Home on an end of life care plan. She said that the discharge letter stated that Resident G was to receive a dose of medication at 22:00 and so his MAR chart was changed to reflect this requirement by the nurse on duty on the night of 28 April 2015. The panel had before it a copy of the hospital discharge letter and Resident G’s MAR chart. Ms 1 further stated that on 29 April 2015 and 30 April 2015, she administered Resident G’s medication to him at 22:00, as directed, and signed his MAR chart to indicate that she had given him his medication. Ms 1 stated that between 28 April 2015 and 30 April 2015, Ms Thistle was not at work at the Home.

Ms 1 further told the panel that on 1 May 2015, Ms Thistle returned to the Home following absence. She stated that on 1 May 2015, she went to administer Resident G’s medication to him at 22:00, as directed in his MAR chart. Ms 1 further stated that Resident G’s medication pot for 1 May 2015 was missing so she proceeded to administer medication from a pot that was left over whilst Resident G was in hospital and signed his MAR chart to indicate that she had administered his medication at 22:00.

Ms 1 stated that on 2 May 2015, at approximately 07:45, she provided a handover to Ms Thistle and informed her that Resident G had slept well and received his medication at 22:00. Ms 1 stated that Ms Thistle asked her why she gave Resident G his medication at 22:00, as she had already administered his medication at 17:00. Ms 1 told the panel that she responded to Ms Thistle that nothing had been documented on Resident G’s MAR chart to reflect a change in administration time and Ms Thistle did not inform her of any changes on the handover of 1 May 2015. Ms 1 further stated that she told Ms
Thistle that the matter needed to be reported. In addition, Ms 1 then stated that she took a picture of Resident G’s MAR chart in order to evidence the fact that no changes had been documented by Ms Thistle. The panel have before it a copy of Resident G’s MAR chart, dated 2 May 2015.

Ms 3 told the panel that she compiled the Home’s staff handover records which confirmed that Ms Thistle had failed to mention any change of medication administration time for Resident G. The panel had before it a copy of the staff handover records. Ms 3 stated that the daily reports for Resident G for between 1 May 2015 and 4 May 2015 were also sourced as part of her investigation, a copy of which was before the panel.

Ms 3 stated that Ms Thistle failed to abide by page 6 of the medication policy, a copy of which was before the panel. Specifically, Ms 3 said that there is a duty to ensure that appropriate records are maintained at all times.

Ms 4 told the panel that if Ms Thistle had signed to state that she had administered Resident G’s medication at 17:00 on 1 May 2015, then, as a nurse caring for Resident G and as the only full time nurse at the Home, she should have ensured that Resident G’s documentation was accurate and correct. Ms 4 stated however that there was now a clear discrepancy with the time of the administration of Resident G’s medication of 17:00 and 22:00 and there were no notes to explain the discrepancy and what the time of the administration should be going forward. Ms 4 further stated that it would be Ms Thistle’s duty to raise the record keeping discrepancy with Ms 4 and Dr 6 and ensure that the document was marked to confirm what the time of the administration of Resident G’s medication was. Ms 4 stated that Ms Thistle had failed to do this.

In light of Ms 1’s consistent and clear oral evidence and the supporting oral and documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle did not contemporaneously record that she administered Mirtazapine to Resident G at 17:00. The panel is also of the view that it is more likely than not that Ms Thistle did not handover that Resident G had received Mirtazapine at 17:00. The panel therefore finds charge 3 proved in its entirety.
Charge 4 – proved

On or after 2 May 2015:

4.1 Did not document that Resident G had received an additional dose of Mirtazapine on 1 May 2015
4.2 Did not escalate that Resident G had received an additional dose of Mirtazapine on 1 May 2015
4.3 Changed Resident G’s drug administration time in respect of Mirtazapine from 22:00 to 17:00 without consulting Resident G’s doctor and/or without clinical justification
4.4 Retrospectively amended Resident G’s medication administration record to record the administration of Mirtazapine at 17:00 on 1 May 2016

Ms 3 told the panel that on the morning of 2 May 2015 Ms Thistle failed to investigate, document and report that Resident G had taken an additional dose of Mirtazapine and she should have informed Ms 4 and Dr 6 immediately.

Ms 4 told the panel that Ms Thistle should have informed her if she had any reason to believe that Resident G received a possible overdose on 1 May 2015 and documented Resident G’s MAR chart as such. Ms 4 also said that Ms Thistle should have completed a drug administration error form and submitted it to her. However, Ms 4 said that Ms Thistle failed to document or inform her of such concerns.

Dr 6 told the panel that between 28 April and 5 May 2015, he was not contacted, and did not approve, a change of Resident G’s drug administration time. He stated that on 13 May 2015, Ms 4 had contacted him to inform him that Resident G may have received two doses of Mirtazapine on 1 May 2015. He said that he informed Ms 4 that Resident G would likely have become drowsier as a result of this but long term side effects would be extremely unlikely.

Ms 1 told the panel that on 2 May 2015, she took a picture of Resident G’s MAR chart in order to evidence the fact that no changes had been documented by Ms Thistle. A copy of Resident G’s MAR chart picture, dated 2 May 2015, was before the panel.
Ms 1 further told the panel that on her return to the Home on 5 May 2015, Resident G’s MAR chart stated that on 1 May 2015 Ms Thistle had administered a dose of medication to Resident G at 17:00. Ms 1 stated that she took a picture of the MAR chart in order to evidence the fact that Ms Thistle had retrospectively changed Resident G’s MAR chart. The panel had a copy of the picture before it of Resident G’s MAR chart from 5 May 2015.

Ms 3 told the panel that during her interview Ms Thistle could not explain what had happened in relation to the allegation that she retrospectively changed Resident G’s MAR chart. Ms 3 stated that it was apparent from the photographs that Ms 1 had taken that Ms Thistle had retrospectively changed Resident G’s MAR chart.

In light of the oral evidence of Ms 3, Ms 4, Dr 6 and Ms 1, as well as the supporting documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle neither documented nor escalated that Resident G had received an additional dose of Mirtazapine on 1 May 2015. The panel is also of the view that it is more likely than not that Ms Thistle changed Resident G’s drug administration time in respect of Mirtazapine from 22:00 to 17:00 without consulting Resident G’s doctor, without clinical justification and retrospectively amended Resident G’s medication administration record to record the administration. The panel therefore finds charge 4 proved in its entirety.
Charge 5.1 – proved

On 12 May 2015:

5.1 Did not administer the following medication to Resident H at 08:00:

5.1.1. 20mg Omeprazole
5.1.2. 75mg Clopidogrel
5.1.3. 40mg Furosemide
5.1.4. 100mcg Levothyroxine

Mr 2 told the panel that on 13 May 2015, he went to administer the teatime medication to four residents in the Acorn Unit at the Home who all suffered from dementia (Resident H, Resident I, Resident B and Resident J). However, Mr 2 stated that the medication that should have been administered to these residents on 12 May 2015 was still in the medication pods.

Mr 2 stated that on 12 May 2015 at 08:00 Resident H was due to receive four tablets from Ms Thistle as evidenced by Resident H’s Patient Information Chart, a copy of which was before the panel. Mr 2 stated that Ms Thistle had signed Resident H’s MAR chart, a copy of which was before the panel, to state that she had administered Resident H’s medication at breakfast time on 12 May 2015. However, Mr 2 stated that the medication pod for the relevant administration time still contained the medication and was intact, as evidenced by the picture of Resident H’s medication pod, a copy of which was before the panel.

Mr 2 further told the panel that Ms Thistle was the nurse in charge on day duty on 12 May 2015 and it was her duty to administer the medication to Resident H, Resident I, Resident B and Resident J. Mr 2 stated that the potential side effects of a resident failing to have their required medication depends on their condition. Mr 2 concluded by stating that for residents who had been diagnosed with dementia, such as these residents, it may mean that they experience a period of increased confusion.

Ms 3 told the panel that that on 27 July 2015, she interviewed Ms Thistle who did not dispute that she had signed for the medication but Ms Thistle could provide no clear explanation as to why the medication pods for that administration time were unused.
In light of Mr 2’s consistent and clear oral evidence and the supporting documentary and oral evidence, the panel is of the view that it is more likely than not that Ms Thistle did not administer the required medication to Resident H at 08:00 on 12 May 2015. The panel therefore finds charge 5.1 proved in its entirety.

**Charge 5.2 – proved**
Incorrectly recorded that you had administered the following medication to Resident H at 08:00:

- 5.2.1. 20mg Omeprazole
- 5.2.2. 75mg Clopidogrel
- 5.2.3. 40mg Furosemide
- 5.2.4. 100mcg Levothyroxine

Mr 2 told the panel that Ms Thistle signed Resident H’s MAR chart to confirm that she had administered Resident H’s medication. However, the medication pod for the relevant administration time still contained the medication and was intact, as evidenced by the picture of Resident H’s medication pod, a copy of which is before the panel.

In light of Mr 2’s consistent and clear oral evidence and the supporting documentary and oral evidence, the panel is of the view that it is more likely than not that Ms Thistle did incorrectly record that she had administered the required medication to Resident H at 08:00 on 12 May 2015. The panel therefore finds charge 5.2 proved in its entirety.

**Charge 5.3 – proved**
Did not administer 20mg Omeprazole to Resident H at 17:00 and/or record the reason for not administering the medication

Mr 2 told the panel that Ms Thistle had not signed Resident H’s MAR chart to confirm that she had administered Resident H’s medication. The medication pod for the relevant administration time still contained the medication and was intact, as evidenced by the picture of Resident H’s medication pod, a copy of which is before the panel.
Mr 2 stated that Ms Thistle failed to abide by the Home’s policy in relation to medication. Page 1 states that there is a duty on the shift leader to ensure that when they are leaving their shift, a resident’s MAR chart is accurately completed and that any outstanding medication issues are highlighted. Mr 2 stated that there is also a duty to ensure that appropriate records are maintained at all times and that the MAR chart must only be signed once the medication has been administered or marked with the appropriate code if not.

In light of Mr 2’s consistent and clear oral evidence and the supporting documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle did not administer 20mg Omeprazole to Resident H at 17:00 and/or record the reason for not administering the medication on 12 May 2015. The panel therefore finds charge 5.3 proved.

Charge 5.4 – proved

Did not administer the following medication to Resident I:
   5.4.1. 75mg Aspirin at 08:00
   5.4.2. 20mg Omeprazole at 08:00
   5.4.3. 30mg Mirtazapine at 17:00
   5.4.4. 200mg Quinine Sulphate at 17:00

Mr 2 told the panel that Resident I was due to receive two doses of medication as above from Ms Thistle on 12 May 2015 at breakfast time and two doses of medication as above from Ms Thistle during the teatime drug round. Mr 2 stated that Ms Thistle signed Resident I’s MAR chart to state that she had administered Resident I’s medication at breakfast time and teatime on 12 May 2015. The panel had before it a copy of Resident I’s MAR chart which corroborates this. Furthermore, Mr 2 stated that the medication pods for the breakfast time and teatime still contained the medication and was intact, as evidenced by the picture of Resident I’s medication pod, a copy of which was in front of the panel.

In light of Mr 2’s consistent and clear oral evidence and the supporting documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle did not
administer the required medication to Resident I at 08:00 and 17:00 on 12 May 2015. The panel therefore finds charge 5.4 proved in its entirety.

Charge 5.5 – proved
Incorrectly recorded that you had administered the following medication to Resident I:

\[
\begin{align*}
5.5.1 & \quad 75\text{mg Aspirin at 08:00} \\
5.5.2 & \quad 20\text{mg Omeprazole at 08:00} \\
5.5.3 & \quad 30\text{mg Mirtazapine at 17:00} \\
5.5.4 & \quad 200\text{mg Quinine Sulphate at 17:00}
\end{align*}
\]

Mr 2 told the panel that Ms Thistle signed Resident I’s MAR chart to state that she had administered Resident I’s medication at breakfast time and teatime on 12 May 2015. The panel had before it a copy of Resident I’s MAR chart which corroborates this.

The panel has already determined that none of this medication was administered.

In light of Mr 2’s consistent and clear oral evidence and the supporting documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle did incorrectly record that she had administered the required medication to Resident I at 08:00 and 17:00 on 12 May 2015. The panel therefore finds charge 5.5 proved in its entirety.

Charge 5.6 – proved
Did not administer 100mg Co-careldopa to Resident B at 17:00

Mr 2 told the panel that Resident B was due to receive one dose of medication from Ms Thistle during the teatime drug round on 12 May 2015. Mr 2 further stated that Ms Thistle signed Resident B’s MAR chart to state that she had administered Resident B’s medication at tea time on 12 May 2015. The panel had before it a copy of Resident B’s MAR chart which corroborates this. Furthermore, Mr 2 stated that the medication pod
for the tea time drug round still contained the medication and was intact, as evidenced by the picture of Resident B’s medication pod, a copy of which was before the panel.

In light of Mr 2’s consistent and clear oral evidence and the supporting documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle did not administer the required medication to Resident B at 17:00 on 12 May 2015. The panel therefore finds charge 5.6 proved.

Charge 5.7 – proved
Incorrectly recorded that you had administered 100mg Co-careldopa to Resident B at 17:00

Mr 2 told the panel that Resident B was due to receive one dose of medication from Ms Thistle during the teatime drug round on 12 May 2015. Mr 2 further stated that Ms Thistle signed Resident B’s MAR chart to state that she had administered Resident B’s medication at tea time on 12 May 2015. The panel had before it a copy of Resident B’s MAR chart which corroborates this. Furthermore, Mr 2 stated that the medication pod for the tea time drug round still contained the medication and was intact, as evidenced by the picture of Resident B’s medication pod, a copy of which was before the panel.

In light of Mr 2’s consistent and clear oral evidence and the supporting documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle did incorrectly record that she had administered the required medication to Resident B at 17:00 on 12 May 2015. The panel therefore finds charge 5.7.
Charge 5.8 – proved
Did not administer a Calceos tablet to Resident J at 17:00

Mr 2 told the panel that Resident J was due to receive one dose of medication from Ms Thistle during the teatime drug round on 12 May 2015. Mr 2 further stated that Ms Thistle signed Resident J’s MAR chart to state that she had administered Resident J’s medication at tea time on 12 May 2015. A copy of Resident J’s MAR chart was before the panel. Furthermore, Mr 2 stated that the medication pod for the tea time drug round still contained the medication and was intact, as evidenced by the picture of Resident J’s medication pod, a copy of which was before the panel.

In light of Mr 2’s consistent and clear oral evidence and the supporting documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle did not administer the required medication to Resident J at 17:00 on 12 May 2015. The panel therefore finds charge 5.8 proved.

Charge 5.9 – proved
Incorrectly recorded that you had administered a Calceos tablet to Resident J at 17:00

Mr 2 told the panel that Resident J was due to receive one dose of medication from Ms Thistle during the teatime drug round on 12 May 2015. Mr 2 further stated that Ms Thistle signed Resident J’s MAR chart to state that she had administered Resident J’s medication at tea time on 12 May 2015. A copy of Resident J’s MAR chart was before the panel. Furthermore, Mr 2 stated that the medication pod for the tea time drug round still contained the medication and was intact, as evidenced by the picture of Resident J’s medication pod, a copy of which was before the panel.
In light of Mr 2’s consistent and clear oral evidence and the supporting documentary evidence, the panel is of the view that it is more likely than not that Ms Thistle did incorrectly record that she had administered the required medication to Resident J at 17:00 on 12 May 2015. The panel therefore finds charge 5.9 proved.

**Charge 6 – not proved**

Your conduct at any or all of charges 2.2 and/or 5.2 and/or 5.5 and/or 5.7 and/or 5.9 was dishonest in that you:

6.1 knew that you had not administered the medication referred to

6.2 intended to create the impression that you had administered the medication

The panel considered the case of *R v Ghosh [1982] Q.B. 1053* and *Fabiyi v Nursing and Midwifery Council [2012] EWHC 1441 (Admin)*. The issue for the panel’s determination was whether it is satisfied upon the balance of probabilities: a) that Ms Thistle’s conduct as found proved in charges 2.2 and/or 5.2 and/or 5.5 and/or 5.7 and/or 5.9 would be regarded as dishonest according to the standards of ordinary and honest nurses; and b) if so (and only if so) that Ms Thistle herself realised at that time that her actions would be regarded as dishonest by those standards. The onus of proof rests throughout on the NMC and the applicable standard of proof is the civil standard, namely on the balance of probabilities.

The panel considered each allegation of dishonesty separately.

The panel first considered whether Ms Thistle’s actions as described in charge 2.2 were dishonest. The panel noted that Resident D’s pills were placed on his bedside table. Ms Thistle signed the MAR chart on the assumption that they had been, or would be, taken. Her intention had been to give Resident D his medication however she failed to ensure that Resident D had consumed them. In these circumstances, the panel was not satisfied that Ms Thistle acted dishonestly.

Whilst the panel considered the allegations relating to charges 5.2, 5.5, 5.7 and 5.9 separately, its determination was the same reasoning for all.
The panel has already determined that Ms Thistle inaccurately recorded that she had administered medication to residents when she had not. The panel was of the view that Ms Thistle was not following the policy and procedure that MAR charts should be signed at the time that medication is administered. She was completing the MAR charts either before or after the medication round. When told of her error by Mr 2 she maintained that she had given the medication. In her meeting with Ms 3 she said that she might have given only boxed medication but not the pods. Her intention had been to give the medication. Her failure was that she had not. This had been compounded by the fact that she did not follow the correct policy for recording that medication had been administered. However, the panel was of the view that this did not amount to dishonesty. Furthermore, she would have been aware that the next nurse on duty would see the medication remaining in the pod.

The panel therefore finds charge 6 not proved.

Charge 7 – proved
Your conduct at charge 4.3 above was dishonest in that you:

7.1 knew that you did not have the authority to change the administration time;
7.2 knew that the change was not clinically justified;
7.3 intended to create the impression that the patient’s medication administration time had changed when that was not the case;
7.4 intended to disguise the fact that administered the medication at the incorrect time on 1 May 2015


The panel noted that this event happened on Ms Thistle’s first day back at work after a period of absence and that she had not had the opportunity to assess the resident’s needs in particular the change of timing of Mirtazapine made by the hospital doctor.
The panel concluded that Ms Thistle changed Resident G’s drug administration time in respect of Mirtazapine from 22:00 to 17:00 without consulting his doctor and without clinical justification. The panel noted Ms 3’s evidence that during her interview Ms Thistle could not explain what had happened in relation to the allegation that she retrospectively changed Resident G’s MAR chart.

Ms 4 told the panel that if Resident G’s time of medication had been changed it would have had to have been authorised by Dr 6. Ms 4 further stated that if Dr 6 authorised this to Ms Thistle over the phone then, as per the Home’s policy, two members of staff would be required to initial the MAR chart and document the change. There was nothing to suggest that Dr 6 had authorised a change of time for the medication to be administered. Ms 4 stated that Ms Thistle should have continued to action Resident G’s medication at 22:00 and raised any concerns regarding the administration time with Dr 6 to review. However, Ms 4 stated that Ms Thistle had failed to do this.

Dr 6 told the panel that between 28 April and 5 May 2015, he was not contacted, and did not approve, a change of Resident G’s drug administration time. He stated that on 13 May 2015, Ms 4 had contacted him to inform him that Resident G may have received two doses of Mirtazapine on 1 May 2015. He said that he informed Ms 4 that Resident G would likely have become drowsier as a result of this but long term side effects would be extremely unlikely.

The panel had before it a copy of the Home’s policy in relation to medication which states that only a qualified practitioner should make changes to a resident’s medication and wherever possible the GP/practitioner should be asked to amend the MAR chart when any changes are necessary.

The panel is satisfied that Ms Thistle would have been aware of the Home’s policy at the time. Therefore the panel is satisfied that on the balance of probabilities she knew that she did not have the authority to change the administration time and that the change was not clinically justified. The panel concluded that it is more likely than not that Ms Thistle intended to create the impression that Resident G’s medication administration time had changed when that was not the case and she intended to
disguise the fact that she had administered the medication at the incorrect time on 1 May 2015.

For all the reasons set out above the panel finds proved that Ms Thistle’s conduct in charge 4.3 was dishonest. The panel therefore finds charge 7 proved.
Determination on misconduct and impairment

The panel considered whether Ms Thistle’s fitness to practise is currently impaired by reason of her misconduct. It has had regard to all the evidence.

The panel has exercised its own judgment in determining the issues before it, and in this context it has considered the need for appropriate weight to be given to the protection of the public, the maintenance of public confidence in the profession, and the upholding of proper standards of conduct and behaviour.

Mr O’Donoughue submitted that Ms Thistle’s conduct fell below what would be expected of a registered nurse. He submitted that she has demonstrated no insight or remediation, and that her fitness to practise is currently impaired by reason of her misconduct.

The panel accepted the advice of the legal assessor.

The panel was referred to the cases of Roylance v General Medical Council (No 2) [2000] 1 A.C. 311 and Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).

The panel concluded on the basis of charges 1 and 2, that Ms Thistle has breached The Code: Standards of conduct, performance and ethics for nurses and midwives (“the 2008 Code”) in the following respects:

21 You must keep your colleagues informed when you are sharing the care of others.

29 You must establish that anyone you delegate to is able to carry out your instructions.

31 You must make sure that everyone you are responsible for is supervised and supported.
42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.

61 You must uphold the reputation of your profession at all times.

The panel concluded on the basis of charges 3, 4, 5 and 7, that Ms Thistle has breached The Code: Professional standards of practice and behaviour for nurses and midwives (“the 2015 Code”) in the following respects:

1 Treat people as individuals and uphold their dignity. To achieve this, you must:
   1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

8 Work cooperatively. To achieve this, you must:
   8.2 maintain effective communication with colleagues
   8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff

10 Keep clear and accurate records relevant to your practice
   This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice. To achieve this, you must:
   10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
   10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
   10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place. To achieve this, you must:
14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations. To achieve this, you must:
18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person’s health and are satisfied that the medicines or treatment serve that person’s health needs
18.4 take all steps to keep medicines stored securely, and

20 Uphold the reputation of your profession at all times. To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

The panel noted that misconduct is not defined in the applicable statutory framework governing the regulatory process of the NMC. The panel had regard to the case of Roylance v General Medical Council (No 2) [2000] 1 A.C. 311 in which the Privy Council held that “serious professional misconduct is not statutorily defined and is not capable of precise description… It must be linked to the practice of medicine or conduct that otherwise brings the profession into disrepute and it must be serious”. It was further held that “misconduct is a word of general effect involving some act or omission that falls short of what would be proper in the circumstances”.

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The panel was satisfied that Ms Thistle’s conduct fell far below what would be expected from a registered nurse and represented a serious departure from the standards contained within the Codes as particularised above. Ms Thistle’s persistent and repeated drug administration errors and poor record keeping put vulnerable residents at risk of harm. She also attempted to dishonestly disguise one of her errors.

The panel accepted that not every breach of the Codes automatically constitutes misconduct. However, the panel was satisfied that Ms Thistle’s actions did amount to serious misconduct and would be regarded as deplorable by fellow professionals.

Having found misconduct, the panel next turned to the question of impairment. It noted that the NMC defines impairment as a registrant’s suitability to remain on the Register without restriction. In approaching the question of impairment the panel took particular account of the wider public interest including the need to protect patients and service users, declare and uphold proper standards of conduct and performance and maintain public confidence in the profession and its regulation.

The panel considered the approach formulated by Dame Janet Smith in her Fifth Report of the Shipman Inquiry, which was cited with approval in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin), as follows:

“Do our findings of fact in respect of the [registrant’s] misconduct, deficient professional performance, adverse health, conviction, caution or determination show that [her] fitness to practise is impaired in the sense that [she]:

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 [nursing] 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 [nursing] profession; and/or”

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.”
The panel first considered whether Ms Thistle’s fitness to practise had been impaired at the time of the incidents in question. The panel had no doubt that she had breached fundamental tenets of the profession to the extent that her conduct had brought the profession into disrepute. In addition, the panel found that Ms Thistle’s conduct had put patients at unwarranted risk of harm. Further, her conduct had included an act of dishonesty. For all these reasons, the panel had no doubt that at the time of the incidents in question Ms Thistle’s fitness to practise had been impaired by reason of her misconduct.

The panel next considered whether Ms Thistle’s fitness to practise remains impaired. To that end, the panel had particular regard to the issues of insight. The panel noted that Ms Thistle has not engaged with the NMC throughout the regulatory process. Consequently, the panel has been provided with no evidence of insight into the impact her actions had on residents and colleagues and the reputation of the profession.

The facts found proved related to clinical failings in the care of vulnerable residents. Ms Thistle’s errors involved basic and fundamental failings in her duties as a registered nurse. Her failings put vulnerable residents at unwarranted risk of harm, brought the profession into disrepute and breached fundamental tenets of the profession.

The panel considered whether Ms Thistle’s misconduct had been remedied and whether it is likely to be repeated. There is no evidence of insight, remorse or remediation therefore there is a real risk of repetition of her misconduct and thereby a risk to patient safety.

On the basis of the above factors, and in the absence of any evidence of steps taken to remedy her practice, the panel therefore concluded that there remains a significant risk of Ms Thistle putting residents at unwarranted risk of harm, bringing the nursing profession into disrepute and breaching fundamental tenets of the profession in the future.

The panel had regard to the wider public interest. It concluded that a finding of current impairment in a case such as this was necessary in order to maintain public confidence
in the profession and to maintain and declare the proper standards of conduct and behaviour to be expected of a registered nurse.

For these reasons the panel has determined that Ms Thistle’s fitness to practise is currently impaired by reason of her misconduct.
Determination on sanction

In reaching its decision on sanction, the panel has considered all the evidence that has been placed before it. The panel has heard the submissions of Mr O'Donoughue, on behalf of the NMC, and has accepted the advice of the legal assessor.

The panel has taken account of the NMC’s Indicative Sanctions Guidance ("ISG"). The panel has had regard to the public interest, which includes the protection of the public and the maintenance of confidence in the profession and the NMC as its regulator. It has applied the principles of proportionality, weighing the interests of the public with Ms Thistle’s interests, and has taken into account the mitigating and aggravating factors in this case.

Mr O'Donoughue invited the panel to exercise its own independent judgment and referred the panel to the ISG.

The panel has approached the question of which sanction, if any, to impose, by considering the least restrictive sanction first and moving upwards. The panel bore in mind that the purpose of a sanction is not to be punitive, although it may have this effect, but is to protect patients and the wider public interest. The wider public interest includes maintaining public confidence in the profession and the regulatory process, and declaring and upholding proper standards of conduct and behaviour.

The panel has identified the following aggravating factors:

- The misconduct related to a number of incidents, repeated on several occasions and involving numerous vulnerable residents;
- Ms Thistle’s misconduct was repeated following a period of supervised practice between the two sets of incidents;
- Ms Thistle’s conduct put residents at serious risk of harm;
- The panel has been provided with no evidence of remorse or insight nor any steps taken by Ms Thistle to remedy her behaviour;
- The panel has identified a risk of repetition.

The panel has identified the following mitigating factors:
• All the witnesses were mostly complimentary about Ms Thistle’s nursing practice;
• There have been no previous referrals to the NMC.

The panel first considered taking no action but concluded that, given the serious nature of the misconduct and its findings with regard to the risk of repetition that this would be wholly inappropriate.

The panel next considered a caution order. Weighing all the circumstances of this case and the seriousness of Ms Thistle’s misconduct, the panel has concluded that a caution order is not a sufficient or appropriate sanction for the same reasons.

The panel next considered the imposition of a conditions of practice order. While the panel considered that Ms Thistle’s drug administration and recording errors could be addressed by the imposition of conditions of practice, it would not be possible, on the information before it, to formulate conditions that would be workable or practicable to deal with the dishonesty found proved. Furthermore, given Ms Thistle’s lack of engagement, the panel has no information before it to suggest that she would be willing to comply with conditions of practice.

The panel next considered a suspension order. The panel is not satisfied that a suspension order would sufficiently mark the seriousness of Ms Thistle’s misconduct. It would not maintain public confidence in the nursing profession, nor would it serve to declare and uphold proper standards of conduct and performance. By making repeated drug administration errors, record keeping errors and dishonestly attempting to disguise an error, Ms Thistle has breached fundamental tenets of the profession and brought the profession into disrepute.

The panel considered the guidance set out in the following paragraphs of the ISG:

35 Dishonesty, even where it does not result in direct harm to patients but is related to matters outside of a nurse or midwife’s professional practice, for example, fraudulent claims for monies, is particularly serious because it can undermine the trust the public place in the profession. Honesty, integrity
and trustworthiness are to be considered the bedrock of any nurse or midwife’s practice.

36 In Parkinson v NMC, Mr Justice Mitting said:
“A nurse found to have acted dishonestly is always going to be at severe risk of having his or her name erased from the register. A nurse who has acted dishonestly, who does not appear before the Panel either personally or by solicitors or counsel to demonstrate remorse, a realisation that the conduct criticised was dishonest, and an undertaking that there will be no repetition, effectively forfeits the small chance of persuading the Panel to adopt a lenient or merciful outcome and to suspend for a period rather than direct erasure.”

37 We do not consider that this decision means that in cases of dishonesty panels are left with an arbitrary choice between suspension and striking-off, or that in the absence of special circumstances a striking-off order is to be seen as a ‘default’ outcome. Rather, this decision makes clear that dishonesty is a highly serious matter and that a striking-off order will almost always be a possible outcome.

Ms Thistle has chosen not to engage in the regulatory process. She has not appeared before this panel. She has not therefore provided the panel with any evidence that she has learnt from her misconduct and will not repeat it in the future. The panel has had no evidence whatsoever of any insight or remorse.

The panel considers that the nature and seriousness of Ms Thistle’s misconduct is fundamentally incompatible with her continued registration as a nurse. As a registered nurse, the panel would expect Ms Thistle to be well aware of the negative and damaging impact on the reputation of the profession of a registered nurse attempting to conceal an error.

In all of the circumstances of this case, the panel concluded that a striking-off order is the appropriate and proportionate sanction. This is necessary to satisfy the public
interest, which includes protection of the public and maintenance of confidence in the profession and the NMC.

Accordingly, the panel determined to direct the Registrar to strike Ms Thistle’s name from the Register.

Ms Thistle may not apply for restoration until five years after the date that this decision takes effect.

**Determination on interim order**

The panel has considered the submissions made by Mr O'Donoughue on behalf of the NMC and has accepted the advice of the legal assessor.

Mr O'Donoughue invited the panel to impose an interim order on the grounds of public protection and it being otherwise in the public interest. He submitted that an interim order should be imposed for 18 months.

The panel has decided to impose an interim suspension order. It has determined for the reasons already given on the substantive order, that it is necessary to do so in the public interest, which includes protection of the public and maintenance of confidence in the profession and the NMC.

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

If no appeal is lodged then the interim order will be replaced by the substantive order 28 days after Ms Thistle is served with the decision of this hearing in writing.