Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing

2 November 2018

Nursing and Midwifery Council, 61 Aldwych, London WC2B 4AE

Name of registrant:	Edgar Guardia Navarro
NMC PIN:	15E0003C
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – May 2015
Area of Registered Address:	Spain
Panel Members:	Melissa D'Mello (Chair, Lay member) Tracey Jary (Registrant member) Paul Leighton (Lay member)
Legal Assessor:	Jayne Salt
Panel Secretary:	Maya Hussain
Mr Navarro:	Not present and not represented
Nursing and Midwifery Council:	Represented by Kim Elcoate May, Case Presenter
Order being reviewed:	Suspension Order (3 months)
Outcome:	Striking off order to come into effect at the end of 7 December 2018 in accordance with Article 30 (1)

Service of Notice of Hearing:

The panel was informed at the start of this hearing that Mr Navarro was not in attendance, nor was he represented in his absence.

The panel was informed that the notice of this hearing was sent to Mr Navarro on 1 October 2018 by international recorded delivery and airmail to his registered address. The track and trace stated that this was not delivered because the address was not recognised. Mr Navarro's change of address from his UK address to his Spanish address was confirmed on 3 August 2016. However since 24 May 2017 all NMC correspondence to Mr Navarro has been returned.

The panel accepted the advice of the legal assessor.

In the light of the information available the panel was satisfied that notice had been served in accordance with Rules 11 and 34 of The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (as amended February 2012) (the Rules).

Proceeding in absence:

Ms May submitted that no request for an adjournment had been made by Mr Navarro and that he had voluntarily absented himself. She reminded the panel that the last correspondence from received from Mr Navarro was on 5 August 2016.

The panel then considered proceeding in the absence of Mr Navarro. The panel was mindful that the discretion to proceed in absence is one which must be exercised with the utmost care and caution.

The panel considered all of the information before it, together with the submissions made by Ms May. The panel accepted the advice of the legal assessor.

Mr Navarro had been sent notice of today's hearing. The NMC's case officer sought confirmation on Mr Navarro's attendance today in an email dated 19 October 2018 and the panel was satisfied that he was or should be aware of today's hearing.

The panel therefore concluded that he had chosen voluntarily to absent himself. The panel had no reason to believe that an adjournment would result in Mr Navarro's attendance. The panel noted that the charges found proved relate to wide ranging nursing skills and a large number of patients. The panel further noted that this is a mandatory review as the current order is due to expire at the end of 7 December 2018. Having weighed the interests of Mr Navarro in regard to his attendance to the hearing with those of the NMC and the public interest in an expeditious disposal of this hearing the panel determined to proceed in Mr Navarro's absence.

Decision and reasons on review of the current order:

The panel decided to impose a striking off order. This order will come into effect at the end of 7 December 2018 in accordance with Article 30 (1) of the Nursing and Midwifery Order 2001 (as amended) (the Order).

This is the third review of a suspension order, originally imposed by a panel of the Conduct and Competence Committee on 8 August 2016 for a period of 12 months. The current order is due to expire at the end of 7 December 2018.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved, by way of admission, which resulted in the imposition of the substantive order were as follows:

> "That you, whilst employed as a Staff Nurse by Peterborough and Stamford Hospitals NHS Foundation Trust at Peterborough City Hospital on Ward A9 (" the Ward") between 16 February 2015 and 5 October failed to demonstrate the standard of knowledge, skill and judgement required for practice without supervision as a Band 5 staff nurse in that:

1. On 14 April 2015 you did not ensure that Patient D had been washed.

2. On 8 May 2015:
    2.1. You did not check Patient S's observations prior to administering medication;
    2.2. You were not able to demonstrate that you understood the uses of the medication that you were administering to Patient S;
    2.3. You recorded Patient U's Glasgow Coma Score as 15 when it should have been 14;
    2.4. You did not complete the admissions booklet for Patient V;
    2.5. You were unable to show to Lesley Probert that you were aware of the process of a medication round.

3. On 11 May 2015:
    3.1. You did not communicate clinical information to a doctor in relation to concerns with Patient W's chest;
    3.2. Following a medical review of Patient W you did not action the treatment requested in an adequately timely manner.

4. On 12 May 2015:
    4.1. You attempted to administer Patient X with an incorrect number of Sinimet tablets;
    4.2. You did not check the identity of Patient Y against the Medication Administration Record that you were using;
    4.3. You dispensed another patient's medication for Patient Y.

5. On 25 May 2015:
    5.1. You did not use the emergency bell in an emergency situation;
    5.2. You used the emergency bell in a non-emergency situation;
    5.3. You were not aware that Co-codomol contained Paracetamol.

6. On 3 June 2015 you did not prioritise feeding patients over washing patients.

7. On 14 June 2015:
    7.1. You did not ensure that you received a thorough handover;
    7.2. You took around one hour to carry out the morning medication round;
    7.3. You were not able to demonstrate knowledge of the uses of the medications that you were administering to your patients;
    7.4. You were not able to demonstrate an understanding of the reason(s) for reviewing a patient's observations prior to administering medication to them;
    7.5. You did not update care plans for your patients;
    7.6. You had to be reminded by Amy Williams to carry out observations for your patients throughout your shift;
    7.7. You were not able to complete Patient FF's fluid balance chart accurately;
    7.8. You did not call a doctor back after 15 minutes to attend Patient GG who was suffering from chest pain;
    7.9. You took around one hour and ten minutes to carry out the evening medication round.

8. On 25 June 2015:
    8.1. You left Patient AA in bed soaked in urine for around one hour;
    8.2. You attempted to change Patient AA's wound dressing whilst Patient AA was lying in a bed soaked in urine;
    8.3. You did not provide care to Patient E who was your allocated patient;
    8.4. You did not recognise the need for standard observations to be performed whilst undertaking neurological observations;
    8.5. You did not provide Patient G with oral fluids after Patient G had returned from a gastroscopy procedure;
    8.6. You did not update care plans for your patients;
    8.7. You were unable to recall basic information of your allocated patients including but not limited to the patients' names, reason(s) for admission to the Ward and plans for the patients' care;

8.8. You were not able to demonstrate knowledge of the basic medications that you were administering to your patients;

8.9. You attempted to leave Patient II whom you were feeding to start the dinner time medication round;

8.10. You attempted to leave the dinner time medication round to escort Patient JJ for an X-ray;

8.11. You were unable to complete Patient KK's fluid balance chart correctly;

8.12. You did not prioritise the completion of your patients' observations.

9. On 26 June 2015:

9.1. You stated that you planned to take observations for your patients and then began to take observations for another nurse's patients;

9.2. You planned to change Patient H's sacral dressing at a time that would have caused Patient H more discomfort than was necessary;

9.3. You did not complete fluid balance charts correctly;

9.4. You did not empty Patient I's catheter when required;

9.5. You did not update the care plans for your patients.

10. On 29 June 2015 you did not use and/or maintain an Aseptic Non Touch Technique when attempting to change Patient BB's wound dressing.

11. On 30 June 2015 you did not attempt to clarify information that you did not understand that had been provided to you at handover.

12. On 7 July 2015:

12.1. You were not able to show that you understood what would be an appropriate dressing for Patient J's wound;

12.2. You began dressing Patient J's wound from mid-way down Patient J's arm;

12.3. You did not complete fluid balance charts for your patients;

12.4. When providing a handover for Patient K to another nurse you stated that Patient K was able sit in their chair with assistance when Patient K was bed bound;

13. On 12 July 2015:
    13.1. You took six and a half hours to read Patient CC's clinical notes;
    13.2. You could not provide Kirsty Ferguson with an adequate handover for Patient CC after reading Patient CC's clinical notes for six and a half hours;
    13.3. You could not provide appropriate treatment for Patient CC when Patient CC complained of a headache.

14. On 15 July 2015:
    14.1. You did not to use the prescribed wound dressing for Patient Q's wound;
    14.2. You did not provide assistance to Patient L who was experiencing a vaso vagal episode.

15. On 18 July 2015 you attempted to have more Navorapid prescribed for Patient DD.

16. On 19 July 2015 you kept Patient DD in bed when Patient DD should have been mobilised.

17. On 22 July 2015:
    17.1. You were not able to show that you understood that when 100ml of fluid per hour was being infused that 100ml of fluid would not have been infused from 10:00 to 10:05.
    17.2. You performed an Electrocardiogram on Patient M because Patient M had low blood pressure;
    17.3. You did not update Patient M's care plan in a timely manner;
    17.4. You did not update Patient M's risk assessment;
    17.5. You did not update Patient M's fluid balance chart.

18. On an unknown date you did not provide appropriate care to Patient A when Patient A had a nose bleed.

19. On an unknown date you were unable to recognise that Patient B needed to be re-cannulated in order for Patient B to continue receiving anti-biotics.

20. On an unknown date you did not assist Patient O when Patient O had fallen.

21. On an unknown date you did not take any steps to assist Patient P when Patient P had an altercation with another patient.

22. On an unknown date you hoisted Patient HH alone and did not stop when Amy Williams told you that you needed to do this with another person.

23. On unknown dates you demonstrated a poor aseptic technique in that you would lean on dressing trolleys and/or would not clean dressing trolleys.

24. On an unknown date:
    24.1. You handed over to another nurse that Patient R required more fluids when Patient R was showing signs of fluid overload.
    24.2. You did not perform a bladder scan when Patient R had not passed urine for 12 hours.

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

The second reviewing panel determined the following with regard to impairment:

> "Regarding Mr Navarro's insight and remediation, the panel noted that the previous panel found that "there is no evidence of remorse, insight or any subsequent remediation." At this hearing the panel was not provided with any new evidence regarding these matters as Mr Navarro had not

engaged. Accordingly, the panel found that the position had not changed and concluded that Mr Navarro still has no remorse, no insight and has not remediated his failings, and in light of this there remains a risk of repetition.

The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel had borne in mind that its primary function was to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel was of the view that Mr Navarro's failings were wide ranging and in some cases related to basic nursing practice. The panel considered that by not engaging with these proceedings, Mr Navarro has demonstrated an unwillingness to comply with his regulator. Accordingly, the panel determined that, in this case, a finding of continuing impairment on public interest grounds is required.

For these reasons, the panel finds that Mr Navarro's fitness to practise remains impaired."

The second reviewing panel determined the following with regard to sanction:

"In light of Mr Navarro's lack of engagement, his decision not to have regard to the two previous panel's recommendations, and the absence of any evidence of insight or remediation, the panel concluded that no workable conditions of practice could be formulated in this case, which would protect the public or satisfy the wider public interest.

In determining whether a suspension order is the appropriate sanction the panel noted that this case involved serious wide ranging clinical failings. Mr Navarro has displayed attitudinal concerns and his lack of engagement suggest a further period of suspension, although would

protect the public, would serve a limited purpose as Mr Navarro has made no suggestion that he is willing to engage or remediate his conduct.

However, before deciding whether to impose a suspension order the panel considered carefully the issue of whether a striking-off order was available to it. The panel took into account the dicta in the case of Okeke v Nursing and Midwifery Council [2013] EWHC 714 (Admin) and the advice of the legal assessor. It also noted the position on the public NMC website although it did not consider itself bound by what is just a further interpretation of the law.

This is such a serious case of lack of competence and complete lack of subsequent engagement that the panel would, had the legal position been clear, have moved to impose a striking-off order as the sanction. However, despite recognising the cost which will be inherent in having a further meeting or hearing, the panel decided to extend the period of suspension by a further three months from the expiry of the current order."

Decision on current fitness to practise:

The panel has considered carefully whether Mr Navarro's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. It has noted the decision of the last panel. However, it has exercised its own judgment as to current impairment.

The panel has had regard to all of the documentation before it. It has taken account of the submissions made by Ms May on behalf of the NMC.

Ms May provided a background of the case to the panel. She submitted that there has been no change in circumstances and Mr Navarro has continued to fail to engage in the NMC proceedings.

Ms May submitted that after the substantive hearing which concluded in August 2016, Mr Navarro was advised in writing as to what a reviewing panel may be assisted by when determining his current fitness to practise. Ms May submitted that Mr Navarro has failed to comply with all of the recommendations made by the substantive hearing and that he has not addressed the concerns found proved. Ms May submitted that in the absence of any insight or remediation, the risk of repetition of the admitted behaviour remains.

Ms May referred the panel to the previous panel's decision on 17 August 2018 where it states that:

> "This is such a serious case of lack of competence and complete lack of subsequent engagement that the panel would, had the legal position been clear, have moved to impose a striking-off order as the sanction."

In light of this, Ms May invited the panel to give careful consideration to the previous panel's comments but reminded the panel that this is a matter for its independent judgment.

The panel heard and accepted the advice of the legal assessor.

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether Mr Navarro's fitness to practise remains impaired. The panel noted the recommendations made by the substantive hearing panel and the subsequent reviewing panels as to what steps Mr Navarro could take to remedy the misconduct and impairment identified. The panel reminded itself that the charges found

in Mr Navarro's nursing practice were potentially remediable. However the panel noted his attitudinal issues and unwillingness to remedy his failures.

The panel noted that the previous panel on 17 August 2018, decided to impose a further suspension order for a period of 3 months to allow Mr Navarro a further and potentially final opportunity to provide any further evidence of remediation. Despite this, today's panel had no evidence before it of Mr Navarro's insight and remediation nor any compliance with these recommendations nor of his ability to be able to practise safely as a nurse. In light of these failings, the panel determined that there remains a high risk of repetition of the lack of competence found proved and that Mr Navarro remains impaired on public protection grounds.

The panel bore in mind that its primary function was to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on the grounds of public interest as well as on public protection grounds is justified.

For these reasons, the panel finds that Mr Navarro's fitness to practise remains impaired.

Determination on sanction:

Having found Mr Navarro's fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 29 of the Order. The panel has also taken into account the NMC's Sanctions Guidance (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel noted the aggravating and mitigating features at the substantive hearing in August 2016. The panel noted that the lack of patient harm was listed as a mitigating factor at that point. This panel was of a different view and thought that potential for

patient harm was significant. It noted that Mr Navarro's consistent lack of engagement is a further aggravating feature of his case.

The panel first considered whether to take no further action but concluded that this would be inappropriate in light of the risks identified and the persistent lack of engagement by Mr Navarro.

The panel then considered whether to impose a caution but concluded that it would be neither proportionate nor in the public interest to impose a caution order. The lack of competence and risk to patients and public is too serious in this case.

The panel next considered the imposition of a conditions of practice order and reviewed the SG. It noted that several points in the SG were engaged making this an unsuitable sanction. Specifically, the panel found that Mr Navarro has failed to engage with the recommendations made by previous panels and that there is evidence of Mr Navarro's general incompetence as a nurse. The panel further determined that there is evidence of Mr Navarro's attitudinal problems. This is exacerbated further by his persistent lack of insight into the seriousness of his actions or their consequences.

The panel next considered imposing a further suspension order. The panel determined that Mr Navarro has continued to demonstrate a persistent lack of insight into his failings and that there is evidence of his attitudinal problems. The panel determined that a further period of suspension would not serve any useful purpose in all of the circumstances, particularly when considering Mr Navarro's complete lack of compliance with the NMC's recommendations as to remediation and his failure to engage with the NMC since 2016.

The panel bore in mind that despite extensive support and training from the Trust and his colleagues Mr Navarro continued to fail to remediate his practice and has demonstrated a persistent lack of insight into his failings. The panel noted that Mr Navarro had been subject to a suspension order for a period of over 2 years and during this time he has failed to engage with his regulator or shown any insight or remediated his practice. The panel determined that the seriousness of this case is incompatible with

ongoing registration when all the circumstances are considered. The panel decided that it was necessary to take action to prevent Mr Navarro from practising in the future and concluded that the only sanction that would adequately protect the public and serve the public interest was a striking-off order.

This decision will be confirmed to Mr Navarro in writing.

That concludes this determination.