Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 9 – Wednesday 11 September 2019
Tuesday 14 – Wednesday 15 January 2020
Nursing and Midwifery Council
114-116 George Street, Edinburgh, EH2 4LH

Monday 7 – Tuesday 8 September 2020
Virtual Hearing

Name of registrant:	**Elizabeth Yankey**
NMC PIN:	10I1715S
Part(s) of the register:	Registered Nurse – sub part 1 Mental Health Nursing (31 August 2013)
Area of registered address:	Paisley
Type of case:	Misconduct
Panel members:	Gail Mortimer (Chair, Lay member) Lucie Moore (Registrant member) Patricia Lynch (Registrant member)
Legal Assessor:	Maria Clarke
Panel Secretary:	Sara Page Ruth Bass (7 – 8 September 2020)
Nursing and Midwifery Council:	Represented by Yusuf Segovia, Case Presenter
Ms Yankey:	September 2019: Present and represented by Louise Bain, instructed by the Glasgow Law Practice January 2020: Not present and not represented in her absence September 2020: Present and represented by Claire Thomas of Beltrami & Co

Facts proved:	Charges 1 – 5 (by way of admission) Charge 6a
Facts not proved:	Charge 6b
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order – 12 months**
Interim Order:	**Conditions of practice order – 18 months**

Details of charge

"That you, a Registered Nurse, whilst working on the Murdostoun Brain Injury Unit on 27 July 2017:

1. Removed, or caused to be removed, Patient B's tracheostomy neck ties / bands;

2. Removed, or caused to be removed, Patient B's outer and/or entire tracheostomy tube;

3. Failed to provide safe tracheostomy care and/or follow the correct procedure when cleaning Patient B's tracheostomy tube / site;

4. Following the removal of Patient B's tracheostomy tube / Patient B bleeding, failed to:

    a. press the emergency buzzer / escalate the concern:

        i. promptly;
        ii. at all;

    b. provide care to avoid blood loss and/or compromising Patient B's airway:

i. promptly;
ii. at all;

5. Acted outside of the scope of your practice / competence by attempting to conduct tracheostomy care to Patient B;

That you, a Registered Nurse, whilst working at the Clachan of Campsie Care Home on 3 August 2018:

6. Failed to take appropriate action in relation to Patient A who was unresponsive / hyper glycaemic in that you:

    a. Did not undertake or record the patient's observations and / or vital signs;

        i. promptly;
        ii. at all;

    b. Did not escalate the patient's condition;

        i. promptly;
        ii. at all

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

Facts

At the outset of the hearing, the panel heard from Ms Bain, on your behalf, who informed the panel that you made full admissions to charges 1 – 5.

The panel therefore finds charges 1 – 5 proved in their entirety, by way of your admissions.

In reaching its decisions on the remaining disputed allegation, charge 6, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Segovia on behalf of the NMC and by Ms Bain.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Band 5 staff nurse who was in charge on shift on 27 July 2017 and to whom the incident with Patient B was reported.

- Witness 2: Senior charge nurse to whom the care of Patient B was handed over when she began her night shift on evening of 27 July 2017.

The panel also had regard to the oral evidence of the following NMC witness:

- Witness 3: Clinical and Deputy Manager of Clachan of Campsie Care Home who attended to Patient A upon reports he was unresponsive.

The panel also heard evidence from you under oath.

Background

On 13 October 2017, the Highland Care Agency (the Agency) raised a concern about your fitness to practise.

Murdostoun Brain Injury Unit

You were working via the Agency at Murdostoun Brain Injury Unit ('the Unit') on 27 July 2017. The Unit is a specialist unit for patients suffering from traumatic brain injuries, brain haemorrhage, or brain injury after an accident or road traffic accident. It is split into two sides, each with 10 bedrooms. On 27 July 2017, the Unit was at full capacity with 20 patients in total. The majority of patients come to the Unit for rehabilitation and though they are usually medically stable, this is not always the case.

Staffing levels are normally two nurses with a minimum of six support workers, plus additional members of the multidisciplinary team. On 27 July 2017, a permanent member of the nursing staff had to attend a training course so an agency nurse was required; you attended in this capacity for the morning shift. You had worked on the Unit on a few previous occasions.

In her written statement, Witness 1 recorded that, as is common practice on the Unit where there are agency nurses on shift, she supervised you at the start of your shift on 27 July 2017 to ensure you knew the routine and the patients, and to be able to answer any questions you may have had. Witness 1 noted that you were asked if you were comfortable to work with tracheostomy patients and you said you were.

Patient B was one of the ten patients assigned to your care on that shift. Patient B was a non-responsive patient who had suffered a road traffic accident and was unable to do anything for himself. He was unable to communicate and was fed through a PEG (Percutaneous Endoscopic Gastrostomy) tube.

Witness 1 noted that at around 11:30, some support workers requested her assistance with Patient B. She recorded that she entered Patient B's room and observed you holding the tracheostomy tube in your hand and she noted that Patient B was bleeding. She recorded that the tracheostomy tube was not in Patient B's throat where it should be.

Witness 1 noted that Patient B's neck ties were unfastened, that he was lying flat, and there was blood obstructing his airway. Witness 1 recorded that she cleaned the stoma site, sat Patient B upright on the bed by using the bed control, dried the stoma area and applied suction. She then inserted a new tracheostomy tube. Witness 1 noted that you watched her but did not assist or try to help. Witness 1 noted that there was no patient harm but the incident could have been fatal. As Patient B is unable to communicate, Witness 1 recorded that it is unclear if he was aware of what happened.

Following the incident, Witness 1 recorded that she completed a Datix (incident reporting) form and documented the incident. The incident was reported to the Agency and the decision was made not to have you return to work on the Unit.

The matter was reported to the NMC and an investigation began into these allegations.

Clachan of Campsie House Care Home

During the course of the NMC investigation a further concern was raised whilst you were working at Clachan of Campsie House Care Home ('the Home'). The Home consists of 95 beds. Whilst there are four units, only two are operational. There is a dementia unit with 11 patients and the general nursing unit which consists of 13 residents. Staffing levels consisted of one nurse, one senior care assistant and two care assistants for each unit. The nurse would be in charge of each unit with support from the Manager, Deputy Manager and Care Home Manager.

You were working as an agency nurse at the Home on 3 August 2018. At the time of the allegations, you were working regularly for the Home, up to five times a week on 12-hour shifts and had previously worked on both units.

Patient A was a frequent short-term resident who was admitted to the Home for respite care. He was diabetic which Witness 3 stated should have been detailed in his handover notes. For respite care patients, these notes should contain information on residents' medical history and current state, mobilisation, likes, and dislikes. It should also detail fluid intake and output and what the resident has eaten.

At the time of the incident, it was noted that Patient A was not on any medication, including for his diabetes, and there was no Medication Administration Record (MAR) chart.

At approximately 14:30 on 3 August 2018, a senior care assistant raised a concern with Witness 3 that Patient A's wife was making accusations that her husband had been sedated by staff as he was unresponsive. Witness 3 stated that she attended to Patient A in the lounge and that, when she arrived, confirmed you were the nurse in charge.

Patient A was in his chair and unresponsive. His wife, who was present, was distressed and in tears. Witness 3 stated that she asked you what Patient A's vital signs were and it is alleged that you responded that you had not taken any. Witness 3 stated that she asked you to obtain the equipment to measure Patient A's blood sugar and instructed that an ambulance be called immediately. She took readings for blood sugar, blood pressure, oxygen saturation levels and temperature for Patient A. The blood sugar reading was recorded as 12.1, which Witness 3 described as *"relatively high [for Patient A]".*

In her oral evidence, Witness 3 was initially unsure as to who made the 999 call and accepted that it could have been you. However, she subsequently asserted that the 999 call had been made by Mr 4, unit manager and registered nurse.

Witness 3 stated that a paramedic who was on site returning another resident assisted her with the incident prior to the arrival of the paramedics as summoned by the 999 call. Patient A was transferred to Royal Glasgow Infirmary.

Witness 3 stated that throughout the incident, you had "*frozen*" and it is alleged that you had not taken any vital signs. It is further alleged that you did not escalate Patient A's condition, only requesting support from Witness 3 when Patient A's wife had accused you of having sedated him.

There was no patient harm as a direct result of the incident. However, Witness 3 stated that the patient could have gone into a coma or a fatality may have occurred if no action had been taken.

Decision and reasons for adjourning the hearing

During the course of your evidence, you referred to the 999 call that you stated that you had made regarding Patient A on 3 August 2018. You stated that, contrary to Witness 3's evidence, it was you who made the call and not another member of staff. You stated that you provided your name and position to the NHS call handler. The panel decided that due to the discrepancy over who had made the call, it should seek to obtain a record of the 999 call as, if the audio or transcript of the call corroborated your version of events, it would greatly assist it in coming to its decision on charges 6a and 6b.

Having discussed with the parties the practicalities of obtaining such evidence, the panel was made aware that it would not be possible to obtain it during the remainder of the hearing as scheduled. In light of this, the panel adjourned the hearing in order for the NMC to contact the Scottish Ambulance Service and request a copy of the audio file

or a transcript or log of all calls made from the Home on 3 August 2018 regarding Patient A.

Accordingly, the case adjourned on Wednesday 10 September 2019.

Hearing resumed on 14 January 2020

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Yankey was not in attendance and that the Notice of Hearing letter had been sent to her registered address by recorded delivery and by first class post on 3 December 2020.

Further, the panel noted that the Notice of Hearing was also sent by recorded delivery and by first class post to Ms Yankey's representative, Ms Bain, at The Glasgow Law Practice on 3 December 2020. In addition, an email was sent to Ms Bain detailing the same information contained within the Notice of Hearing letter, also dated 3 December 2020.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Ms Yankey's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Segovia, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules).

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Ms Yankey has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Yankey

The panel next considered whether it should proceed in the absence of Ms Yankey. The panel had regard to Rule 21(2), which states:

> *'**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.'*

Mr Segovia informed the panel that an email was received from Ms Bain, dated 13 January 2020 at 14:40. [PRIVATE]

Mr Segovia submitted that there had been no correspondence from Ms Yankey at all in relation to either Ms Bain's withdrawal as her representative or to apply for an adjournment of these proceedings. Accordingly, Mr Segovia invited the panel to proceed in Ms Yankey's absence.

Having accepted the advice of the legal assessor, the panel was concerned that the information provided by Ms Bain in her email had some bearing on Ms Yankey's failure to attend the hearing. In order to ensure Ms Yankey had an opportunity to inform the panel herself of her personal circumstances and/or to apply for adjournment, the panel requested that Ms Yankey's NMC case co-ordinator make attempts to contact her before the panel considered whether or not to proceed in her absence.

An email was sent to Ms Yankey at 10:14 informing her that the resuming hearing was taking place and explaining that Ms Bain had informed the NMC she was no longer representing Ms Yankey. The email asked Ms Yankey to contact the NMC as soon as possible with her intentions for the hearing. In addition, an unsuccessful telephone call was made and a voice message left.

The panel asked for an update from the NMC case co-ordinator at 13:00.

Having had confirmed at 13:00 that Ms Yankey had not responded to either the email or the voice message, the panel went into camera to discuss whether or not to proceed in her absence. In order to be as fair to Ms Yankey as possible, the panel concluded that it would allow Ms Yankey until 09:00 on Wednesday 15 January 2020 to respond to the email and make her intentions known. It directed the NMC case co-ordinator to email Ms Yankey a further time explaining in clear detail that the panel has not proceeded with the hearing so far in order to allow Ms Yankey to contact the NMC. The email explained the option for Ms Yankey to apply for an adjournment and to explain, and provide evidence for, her reasons. It also made clear that if Ms Yankey failed to make contact with the NMC there would be a real possibility that the hearing may proceed in her absence.

The panel reconvened at 09:00 on Wednesday 15 January 2020. Mr Segovia confirmed that no contact had been made by Ms Yankey in relation to these proceedings.

Therefore, Mr Segovia invited the panel to consider his application to proceed in her absence.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R.* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

As Ms Yankey has still not responded to any of the emails or telephones calls, the panel has decided to proceed in her absence. In reaching this decision, the panel has considered the submissions of Mr Segovia and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Yankey;
- Ms Yankey has not engaged with the NMC and has not responded to any of the letters and emails sent or telephone calls made to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Yankey in proceeding in her absence. The panel was aware of its decision to adjourn previous proceedings in order for the NMC to contact the Scottish Ambulance Service and request a copy of the audio file or a transcript or log of all calls made from the Home on 3 August 2018 regarding Patient A. If such evidence has been obtained, and is presented to the panel, Ms Yankey will not able to respond to it.

However, the panel took into account that, at the hearing in September 2019, Ms Yankey had given her evidence under oath on the disputed facts and had also been fully examined by her representative Ms Bain and cross-examined by Mr Segovia on behalf of the NMC. In the panel's judgement, the disadvantage to Ms Yankey would be mitigated by its thorough exploration of any inconsistencies in the evidence which it identified.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Ms Yankey. The panel will draw no adverse inference from Ms Yankey's absence in its findings of fact.

Decisions and reasons on charge 6

Mr Segovia informed the panel that, since the hearing adjourned in September 2019, the Scottish Ambulance Service had provided a copy of the audio file of the 999 call made. He provided the panel with a copy of a cover email from the Associate Director of Care Quality and Professional Development, a part of the Scottish Ambulance Service, which stated:

"...I have now had an opportunity to obtain... the following information:

- *Call Sequence of Events*
- *Patient Care Record*
- *999 Audio Call Recording*

...We do not routinely record the identity of callers to 999, as a consequence the only information recorded in the sequence of events is that it was a second party caller (i.e. the call was not made by the patient themselves, moreover there is nothing recorded with the patient care record to identify who was responsible for making the 999 call, or the care of the patient prior to our attendance..."

In the light of this information, Mr Segovia submitted that as it was impossible to identify the caller, the audio recording should not be heard by the panel. He submitted that it would be speculative to say whether the caller was male or female and that they are not identified by name. As Ms Yankey, nor any representation on her behalf, are present to confirm or deny that it is Ms Yankey's voice recorded on the audio file, the panel would be unable to draw any conclusions from it. He submitted the recording would therefore be of little or no evidential value and so would not assist the panel further in its deliberations on charge 6.

In order to assist the panel, Mr Segovia reiterated that the Scottish Ambulance Service confirmed that only one call was made from the Home, on 3 August 2018, regarding Patient A.

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

Given that Ms Yankey is not present and in the absence of being able to identify the caller on the audio file, the panel was of the view that it would not be appropriate to admit the audio file into evidence.

Before making any findings on the disputed facts, charge 6a and 6b, the panel considered the witness and documentary evidence provided by both the NMC and Ms Bain on Ms Yankey's behalf.

The panel considered the live evidence and made the following conclusions:

Witness 3: The panel considered the evidence of Witness 3 to be consistent and overall credible. She made it clear when she could not recall events with the requisite detail and clarity and did not seek to elaborate her answers or proffer alternative suggestions. The panel found her to be fair, balanced and measured.

Ms Yankey: The panel found that Ms Yankey's evidence was consistent with her one previous account of the events. She appeared to give a clear account of events as she remembered them and appeared honest.

The panel then considered each of the allegations in charge 6 and made the following findings.

Charge 6a

> "That you, a Registered Nurse, whilst working at the Clachan of Campsie Care Home on 3 August 2018, failed to take appropriate action in relation to Patient A who was unresponsive / hyper glycaemic in that you:
>
> a. Did not undertake or record the patient's observations and / or vital signs;
>
> i. promptly;
>
> ii. at all."

This charge is found proved, in respect of not undertaking observations.

Undertaking observations

Ms Yankey stated in her evidence that when was called to see Patient A, she found him to be unresponsive and so had taken his vital signs. She said that she remembered doing so as she used her own equipment which she kept with her as the equipment at the Home was not always functional. She remembered that, at the time she was trying to take Patient A's vital signs, his wife was agitated, shouting and making accusations.

Witness 3 told the panel that when she arrived at the lounge, she found Patient A unresponsive and Ms Yankey was "*frozen*". She stated that she noticed that Ms Yankey

was not near to the patient and was not involved in his care at all. Witness 3 recalled that she could smell a sweet smell on Patient A's breath which led her to believe that he may have been hyper glycaemic. She asked Ms Yankey what his blood sugar levels were. She stated that Ms Yankey did not know and then instructed her to get the equipment to start taking his vital signs and blood sugar levels.

In the incident report, it records: *"Resident become unresponsive after lunch. Nurse failed to respond. [Ms Yankey] informed relative that [Patient A] was fast asleep."* This report, dated 3 August 2018, was signed by both Witness 3 (the Home Manager) and the nurse in charge of a different unit in the Home.

In the hand written statement of a member of the care staff, present at the time of the incident with Patient A, it states *"...the nurse went to get the manager so she came into the unit and started talking to Patient A...the manager was dealing with the situation at this time..."*

Neither of the written accounts from the two care assistants who appear to have been present at the time state that Ms Yankey was undertaking any observations of Patient A. It was also recorded in Patient A's daily notes of 4 August 2018 at 10:00 that his wife had made a complaint as "*staff had no idea what to do*" when her husband was found to be unresponsive.

Having considered all the evidence before it, the panel was concerned that aside from Ms Yankey's assertions that she undertook Patient A's observations, there is no mention from any other witnesses that she had done so. The panel also found Witness 3's account to be credible. She provided a very detailed description of the scene that met her when she entered the lounge. Overall, the panel preferred Witness 3's account to that of Ms Yankey.

Therefore, the panel found on the balance of probabilities that Ms Yankey did not undertake the observations promptly or at all.

Recording observations

The panel took into account that a set of vital signs and a blood sugar level had been recorded in Patient A's notes, in an entry timed at 18:00. These notes had been signed and initialled by Ms Yankey. Witness 3 also recorded these on the incident report, which Witness 3 says she herself completed at approximately 14:30.

In her oral evidence, Ms Yankey told the panel that she had written Patient A's observations in a notepad she kept in the pocket of her tunic. In Witness 3's oral evidence, she accepted that when she was undertaking Patient A's observations, Ms Yankey was documenting them. In the light of all the supporting evidence, the panel found that it was more likely than not that Ms Yankey had been making a note of the observations as Witness 3 had taken them and she had then used these to compile her notes at 18:00.

Therefore, the panel found that Ms Yankey did record the observations, both at the time of the incident and later in Patient A's daily notes.

Accordingly, the panel finds charge 6a not proved, with regards to recording.

Charge 6b

> "That you, a Registered Nurse, whilst working at the Clachan of Campsie Care Home on 3 August 2018, failed to take appropriate action in relation to Patient A who was unresponsive / hyper glycaemic in that you did not escalate the patient's condition;
>
> i. promptly;
>
> ii. at all."

This charge is found NOT proved.

The panel took into account that the NMC's case focused on whether or not Ms Yankey escalated Patient A's condition by calling 999 to request an ambulance.

The information provided by the Scottish Ambulance Service is clear that a 999 call was made in relation to Patient A on 3 August 2018. However, the identity of the caller was not recorded.

In her oral evidence, Witness 3 could not, at first, say with any certainty whether it had been Ms Yankey, another nurse who was present, or a carer who had called 999. Later in her oral evidence, her position changed and she asserted that it *"definitely"* was a nurse, other than Ms Yankey, who had made the call.

In her evidence, Ms Yankey stated plainly that she had called the ambulance herself and had provided her name and position to the NHS call handler.

Owing to the ambiguity of Witness 3's evidence, and in the absence of other clear evidence, the panel was unable to ascertain who had made the call.

Therefore, the panel found charge 6b not proved.

Hearing resumed on 7 September 2020

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to

practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

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

Mr Segovia identified the specific, relevant standards where your actions amounted to misconduct. He submitted that you had acted out of your scope, in particular with Patient B, by attempting to carry out tracheostomy care, and had failed to escalate the matter. He also submitted that you had failed to give the appropriate care and had compromised patient B's airways.

Mr Segovia submitted that the potential for serious harm to both Patient A and Patient B was high. In particular with regard to Patient B he reminded the panel that you were asked specifically whether you were comfortable working with tracheostomy patients, and that you had said yes. He submitted that your failure in acting outside of the scope of your practice, and your failure to escalate concerns and do what was required of you, compromised the safety of the patients.

Ms Thomas, on your behalf, told the panel that you did not seek to minimise the seriousness of the allegations found proved. She stated that on both occasions you admitted that, in respect of Patient A and Patient B, you did not give the proper standard of care.

Submissions on impairment

Mr Segovia moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) *(Grant).*

Mr Segovia submitted that there had been the potential for serious harm to both patients if others had not intervened. He also submitted that you had breached fundamental tenets of the nursing profession and that this was evidenced by the number of breaches of the Code. He further submitted that your misconduct had brought the nursing profession into disrepute.

He invited the panel to look at the issues of insight and remediation. He submitted that if there was no evidence of appropriate insight or remediation then the panel could conclude that there is the potential risk of repetition in the future.

Ms Thomas submitted that there had been no indication of a lack of competence throughout your career. She submitted that the two incidents did not represent a fair sample of your work and that there had been no previous concerns regarding your practice. She told the panel that following the incident in 2017, you had worked for 11 months as a private nurse for the same employer, albeit not carrying out tracheostomy care.

Ms Thomas submitted that your failings in this case were remediable and had been remediated. She referred the panel to training you had undertaken in 2019, which included a certificate for adult tracheostomy care dated July 2019. She submitted that you have undertaken the necessary training in order to bring your skills up to the appropriate level. She further submitted that the training had addressed the clinical concerns identified in your practice.

Ms Thomas reminded the panel that you are currently subject to an interim order which restricts you from carrying out tracheostomy care until you are assessed and signed off as competent to do so. She told the panel that due to the restrictive nature of the current conditions of practice order you have not been able to secure a job as a nurse and have been working as a healthcare assistant since March 2019. Ms Thomas told the panel that you have undertaken all of the necessary training to remedy the concerns which have been raised and have demonstrated reflection and insight into your conduct. She submitted that your fitness to practise is no longer impaired.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work co-operatively

To achieve this, you must:

8.5 work with colleagues to preserve the safety of those receiving care

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.5 complete the necessary training before carrying out a new role

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

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that these were very serious allegations that have been found proved. You acted outside of the scope of your competence in respect of Patient B, as you had not had the required tracheostomy training since 2015, and although no harm was caused, there was potential to cause harm by attempting to undertake a tracheostomy procedure which was outside of your training. You also failed to respond to signs of deterioration in Patient A or escalate concerns regarding Patient B, which in both cases could have led to patient harm. The panel found that these failings, in addition to acting beyond the limits of your competence, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

The panel finds that patients were put at risk of harm as a result of your misconduct, and that your actions breached fundamental tenets of the nursing profession and, as a result, brought its reputation into disrepute.

Regarding insight, the panel had regard to your reflective piece dated 25 April 2019. It noted that you have accepted you made some very *'serious mistakes'* and have apologised unreservedly and expressed remorse, which it deemed to be genuine. Furthermore, it had regard to the fact that you had made admissions in respect of charges 1 – 5, had demonstrated an understanding of how your actions put patients at risk of harm, and acknowledged the impact your actions had had on public confidence in the nursing profession. You further acknowledged that your conduct fell short of the professional standards required and that you had taken remedial steps to minimise the risk of repetition. The panel was therefore satisfied that you had demonstrated sufficient insight into your actions.

The panel was satisfied that the misconduct in this case is capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not you have remedied your practice. The panel acknowledged your attempt to remedy the failings by undertaking relevant courses. It noted that you had taken some steps to try and remediate the misconduct, however had been unable to do so in a clinical setting.

The panel had regard to the training certificates provided. Although numerous, the panel noted that the majority of certificates did not go to the issues in concern, namely tracheostomy care and responding to signs of deterioration in a patient. The panel particularly had regard to the diabetic training and tracheostomy care training undertaken in June 2017 and July 2019 respectively. However the diabetes training had been focused on foot care/screening and not recognising and responding to signs of

general deterioration in the diabetic patient. Further, it noted that you had not been able to gain employment as a nurse since undertaking these courses, and found that you had therefore not been able to put the theoretical learning into clinical practice and demonstrate full remediation. The panel was therefore of the view that there is a risk of repetition based on the fact that you have not practised as a nurse, and essentially have not had an opportunity to demonstrate that you are now competent in these areas. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because members of the public, knowing that a nurse had acted outside of their training and placed a patient at a significant risk of harm, and who had failed to respond to and escalate matters in critical circumstances, would be extremely concerned by these failures.

In addition, the panel concluded that, given the allegations found proved, public confidence in the profession would be undermined if a finding of impairment were not made in this case. Therefore the panel also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Submissions on sanction

Mr Segovia informed the panel that in the Notice of Hearing, dated 31 July 2019, the NMC had advised you that it would seek the imposition of a conditions of practice order for 12 months if it was found that your fitness to practise is currently impaired.

The panel also bore in mind Ms Thomas' submissions. Ms Thomas told the panel that you have not been able to secure employment as a nurse to demonstrate your clinical skills. She submitted that you have undertaken training and courses in an attempt to remediate the concerns identified. She submitted that any risk to the public, and the public interest, could be dealt with by a less restrictive sanction for a period of 6 months.

Ms Thomas told the panel that Condition 1 of the current order was very restrictive, in that you needed to be supervised at all times. She appreciated the need for supervision in respect of diabetic patients and tracheostomy care, but submitted that Condition 1 went beyond those issues and brought into question your entire practice which has not been subject to scrutiny. She reminded the panel that you had worked for 11 months after the incidents and there were no issues with your ability to provide nursing care.

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

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- These were two separate incidents of misconduct which placed patients at a significant risk of harm

The panel also took into account the following mitigating features:

- Your early admissions in respect of charges 1 – 5
- You have apologised and expressed remorse for the admitted incidents
- You have demonstrated an understanding of the seriousness of your actions
- You have undertaken remediable steps
- You are a nurse of previous good character
- You have taken steps to keep up to date with your nursing practice

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the public protection issues identified and the seriousness of the charges found proved. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the charges found proved, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*

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

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that these incidents happened some time ago and that, other than these incidents, you have had an unblemished career as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case in light of the steps you have taken to remediate, the insight shown into your misconduct, and your willingness to cooperate with these proceedings and address your failings

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the

profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

1. At any time that you are employed or otherwise providing nursing services, you must place yourself and remain under the supervision of a workplace line manager, mentor or supervisor nominated by your employer. Such supervision is to consist of working at all times on the same shift as, but not necessarily under the direct observation of, a registered nurse who is physically present in or on the same ward, unit, floor or home that you are working in or on.

2. If you are employed in a clinical environment where there are patients requiring tracheostomy care you must not undertake tracheostomy care until you have been deemed competent in such care by a nurse suitably qualified in tracheostomy care who has observed your practice. Your competence must be confirmed in writing and a copy forwarded to the NMC prior to any NMC review meeting or hearing.

3. You must complete appropriate training regarding the care and management of patients with diabetes, which includes recognising signs of deterioration in a patient's condition and how to respond to it. Evidence of the completed training must be forwarded to the NMC prior to any NMC review meeting or hearing.

4. Wherever you are employed in a nursing role, you must send a report from your employer, clinical line manager, mentor or supervisor (or their nominated deputy) setting out the standard of your performance with particular reference to tracheostomy care (if such care has been provided) and responding to signs of deterioration in the unresponsive patient to the NMC prior to any NMC review meeting or hearing.

5. You must tell the NMC within 7 days of any nursing appointment (whether paid or unpaid) you accept within the UK or elsewhere, and provide the NMC with contact details of your employer.

6. You must tell the NMC about any professional investigation started against you and/or any professional disciplinary proceedings taken against you within 7 days of you receiving notice of them.

7. a) You must within 7 days of accepting any post or employment requiring registration with the NMC, or any course of study connected with nursing or midwifery, provide the NMC with the name/contact details of the individual or organisation offering the post, employment or course of study;

   b) You must within 7 days of entering into any arrangements required by these conditions of practice provide the NMC with the name and contact details of the individual/organisation with whom you have entered into the arrangement;

8. You must immediately tell the following parties that you are subject to a conditions of practice order under the NMC's fitness to practise procedures, and disclose the conditions listed at 1 to 7 above, to them:

   a. Any organisation or person employing, contracting with, or using you to undertake nursing work;
   b. Any agency you are registered with or apply to be registered with (at the time of application) to provide nursing services;
   c. Any prospective employer (at the time of application) where you are applying for any nursing appointment; and
   d. Any educational establishment at which you are undertaking a course of study connected with nursing or midwifery, or any such establishment to which you apply to take such a course (at the time of application).

The panel was of the view that the conditions as formulated will not prevent you from seeking employment as a nurse. Condition 1, as stated, refers to indirect supervision which will enable you to work within a care environment where another nurse is physically present in or on the same ward, unit, floor or home that you are working in or on. The conditions will provide you and the public with the necessary safeguards to ensure safe and effective clinical practice.

The period of this order is for 12 months, to allow you an opportunity to find employment as a nurse.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

In addition to the evidence required by the above conditions any future panel reviewing this case would be assisted by:

- Your attendance
- References and testimonials from any paid or unpaid work you are undertaking, from individuals with knowledge of these proceedings
- Any other evidence which you feel would assist the panel

This will be confirmed to you in writing.

Interim order

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

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

Submissions on interim order

The panel took account of the submissions made by Mr Segovia. He submitted that, due to the panel making a conditions of practice order, an interim order was required to protect the public and the public interest. My Segovia invited the panel to make an interim suspension order for a period of 18 months.

Ms Thomas made no representations.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover any appeal period.

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

That concludes this determination.