Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 19 April 2021

Virtual Hearing

Name of registrant:	Lesley Anne Watts
NMC PIN:	12G0230E
Part(s) of the register:	RNA - Registered Nurse - Adult (April 2013)
Area of registered address:	Lincolnshire
Type of case:	Misconduct
Panel members:	Wendy Yeadon (Chair, Lay member) Michael Murphy (Registrant member) Rachel Childs (Lay member)
Legal Assessor:	Nigel Mitchell
Panel Secretary:	Christine Iraguha
Nursing and Midwifery Council:	Represented by Isabelle Knight, Case Presenter
Mrs Watts:	Not present but represented by Briony Molyneux of Counsel, instructed by the Royal College of Nursing (RCN)
Consensual Panel Determination:	Accepted
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (18 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge

'That you a Registered Nurse,

1. On the 3rd September 2017 having been aware that Patient A had been laying prone in her cell throughout the night and during the day, failed to conduct physical and clinical observations upon them;
(a) Around 07.30
(b) Around 12.00
(c) Around 14.55

2. On the 3rd September 2017 in respect of Patient A you failed to conduct clinical observations by;
(a) Not checking Patient A for wounds
(b) Not checking Patient A's airways
(c) Not checking Patient A's physical presentation
(d) Not checking Patient A's blood pressure
(e) Not checking Patient A's oxygen saturation levels
(f) Not checking Patient A's blood sugar levels

3. On the 3rd September 2017 by not conducting clinical assessments, you failed to recognise deterioration of Patient A.

4. On the 3rd September 2017 by not conducting clinical assessments you failed to act upon the deterioration of Patient A.

5. On the 3rd September 2017 you physically abused Patient A by throwing a cup of water over them.

6. On the 3rd September 2017 you verbally abused Patient A by saying;

(a) "There are residents that are really ill and they are having to wait to see me because I have got to come and see you, you need to get up, you are pathetic" or words to that effect.
(b) "You haven't pissed yourself, this is what you've done" and/or "you haven't wet yourself you've just done that" or words to that effect.

7. On the 14th September 2018 in respect of Patient B failed to carry out observations between 08.00 and 16.00 hours.

8. On the 14th September 2018 in respect of Patient B failed to carry out observations on an hourly basis between 16.00 and 20.00 hours.

9. On the 14th September 2018 having not carried out observations as mentioned in charges 7 and 8, failed to recognise that Patient B's health was deteriorating.

10. Patient B having been prescribed insulin (Novo Rapid) on the 14th September 2018 at 12.50 hours failed to administer the medication immediately following the prescription being given.

11. Patient B having been prescribed insulin (Novo Rapid) on the 14th September 2018 at 17.30 hours failed to administer the medication immediately following the prescription being given.

And in light of the above your fitness to practice is impaired by reason of your misconduct'.

Consensual Panel Determination

At the outset of this hearing, Ms Knight, on behalf of the Nursing and Midwifery Council (NMC) informed the panel that a provisional agreement of a Consensual Panel

Determination (CPD) had been reached with regard to this case between the NMC and the Royal College of Nursing (RCN) on Mrs Watts' behalf.

Ms Knight said that parties agree that the suggested sanction should be a conditions of practice order for 18 months and an interim order for the same period. She referred the panel to the CPD document and outlined the background to the facts and charges. She submitted that the panel should consider current impairment, whether the facts admitted amount to misconduct, whether Mrs Watts' fitness to practise is impaired and whether her conduct fell short of the standards of behaviour expected of a registered nurse. She referred the panel to paragraph 73 of the CPD which shows the relevant parts of the Code that have been breached. She submitted that the conduct had the potential to cause harm but Mrs Watts' actions did not result in Patient A's death. Mrs Watts accepted that her conduct in both incidences fell short of the standards required.

Ms Knight submitted that the parties agree there are attitudinal concerns that are difficult to remediate, but there are mitigating factors, and these can be remedied. Mrs Watts has shown regret, remorse and has undertaken relevant learning to address the areas of concern. Ms Knight stated that Mrs Watts has not had the opportunity to remediate because she has not worked as a registered nurse since 2018. Ms Knight submitted that Mrs Watts' fitness to practise is currently impaired on public protection and public interest grounds. She said that parties agree that a conditions of practice order for a period of 18 months with a review is the appropriate sanction. She referred the panel to the aggravating and mitigating features, and also to the positive testimonials. She said that there are no other regulatory concerns before or after these matters and submitted that there was no suggestion that the attitudinal concerns are deep seated.

Ms Molyneux, on behalf of Mrs Watts, submitted that the CPD is the agreed approach between the RCN and the NMC. She said that Mrs Watts has admitted to the charges, misconduct and impairment is accepted. She stated that the allegations are old, occurred in 2017 and 2018, and invited the panel to consider the agreed conditions of

practice order. Ms Molyneux said that Mrs Watts has had an unblemished career and was practising with no concerns before and after these allegations. Albeit, Mrs Watts has not been working as a nurse since 2018 but has continued to work within the healthcare sector. She said that the 2017 incident involving Patient A occurred in prison and that Patient A had a history of challenging behaviour. She said that Mrs Watts is not using this as an excuse and is extremely sorry that she was influenced by other staff members. Ms Molyneux invited the panel to consider the contextual elements to the charges and stated that Mrs Watt's actions did not contribute to Patient A's death. Regarding the charges in 2018 involving Patient B, Ms Molyneux said that the incident occurred when Mrs Watts was on her first shift. She had moved from a low dependency ward to working with patients who were acutely unwell with different clinical needs. Ms Molyneux said that Mrs Watts is not using this as an excuse but she was feeling quite overwhelmed. Although, there was some harm to patient B, the patient recovered fully. She submitted that Mrs Watts has shown considerable remorse for her behaviour, and has provided a comprehensive reflective statement that demonstrates the actions she has taken to address the failings. She has also provided positive testimonials and evidence of multiple training she has undertaken to address the areas of concern. Ms Molyneux stated that the conditions of practice agreed are appropriate, proportionate and workable. She said that the supervision will ensure that Mrs Watts is working at the required standard and that her actions at the time of the incidents were out of character. Ms Molyneux said that Mrs Watts is a good nurse and can practice safely.

The panel accepted the advice of the legal assessor.

The agreement, which was put before the panel, sets out Mrs Watts full admissions to the facts alleged in the charges, that her actions amounted to misconduct and that her fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a conditions of practice order for a period of 18 months with a review. Parties agree that an interim order is required in this case, for the protection of the public and is otherwise in the public interest. The order should be for a period of 18 months to guard against the risk to the

public in the event that Mrs Watts seeks to appeal against the substantive order. The interim order should take the form of an interim conditions of practice order with conditions mirroring those of the substantive order.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

> *'The Nursing and Midwifery Council and Lesley Anne Watts ('the Registrant'), PIN 12G0230E, ('the Parties') agree as follows:*
>
> ***The Charges***
>
> *The Registrant admits the following charges:*
>
> *That you a Registered Nurse,*
>
> *1. On the 3rd September 2017 having been aware that Patient A had been laying prone in her cell throughout the night and during the day, failed to conduct physical and clinical observations upon them;*
> *(a) Around 07.30*
> *(b) Around 12.00*
> *(c) Around 14.55*
>
> *2. On the 3rd September 2017 in respect of Patient A you failed to conduct clinical observations by;*
> *(a) Not checking Patient A for wounds*
> *(b) Not checking Patient A's airways*
> *(c) Not checking Patient A's physical presentation*
> *(d) Not checking Patient A's blood pressure*
> *(e) Not checking Patient A's oxygen saturation levels*

(f) Not checking Patient A's blood sugar levels

3. On the 3rd September 2017 by not conducting clinical assessments, you failed to recognise deterioration of Patient A.

4. On the 3rd September 2017 by not conducting clinical assessments you failed to act upon the deterioration of Patient A.

5. On the 3rd September 2017 you physically abused Patient A by throwing a cup of water over them.

6. On the 3rd September 2017 you verbally abused Patient A by saying;
(a) "There are residents that are really ill and they are having to wait to see me because I have got to come and see you, you need to get up, you are pathetic" or words to that effect.
(b) "You haven't pissed yourself, this is what you've done" and/or "you haven't wet yourself you've just done that" or words to that effect.

7. On the 14th September 2018 in respect of Patient B failed to carry out observations between 08.00 and 16.00 hours.

8. On the 14th September 2018 in respect of Patient B failed to carry out observations on an hourly basis between 16.00 and 20.00 hours.

9. On the 14th September 2018 having not carried out observations as mentioned in charges 7 and 8, failed to recognise that Patient B's health was deteriorating.

10. Patient B having been prescribed insulin (Novo Rapid) on the 14th September 2018 at 12.50 hours failed to administer the medication immediately following the prescription being given.

11. Patient B having been prescribed insulin (Novo Rapid) on the 14th September 2018 at 17.30 hours failed to administer the medication immediately following the prescription being given.

And in light of the above your fitness to practice is impaired by reason of your misconduct.

Agreed Facts:

1. The Registrant first registered as a nurse in 2013.

2. The Registrant started work as a registered nurse at HMP Peterborough Prison (the "Prison") in April 2014 and was dismissed from her post on the 30th January 2018, after a disciplinary hearing for gross misconduct.

3. The Registrant began working as a registered nurse at the Hinchingbrooke Hospital (the "Hospital"), Cherry Tree Ward on the 4th June 2018 and was moved to the Plum Tree Ward on the 14th September 2018. The Registrant was suspended from her position at the Hospital on the 28th September 2018. On the 26th April 2019, following a disciplinary hearing at the Hospital, the Registrant was downgraded permanently to a Band 2 Healthcare Assistant and recommenced her employment at the Hospital in this role on the 17th June 2019. The Registrant resigned from this post on the 31st December 2020.

4. The Registrant is currently employed with the APMS Ambulance Service as an Ambulance Care Assistant for Patient Transport Services and Emergency Care Assistant/First Responder L3, having commenced this role in July 2019.

5. Charges 1 – 6 relate to when the Registrant was employed at the Prison, and the evidence relating to these charges emanate from the following witnesses:

Colleague 1 (Senior Investigator at the Prison and Probation Ombudsman), Colleague 2 (Clinical Reviewer commissioned by NHS England), Colleague 3 (Head of Healthcare for Sodexo Justice Services), Colleague 4 (Prison Officer), Colleague 5 (Prison Officer), Colleague 6 (Clinical Nurse Manager at HMP Peterborough).

6. Charges 7 – 11 relate to when the Registrant was employed at the Hospital and the evidence relating to these charges emanate from the following witnesses: Colleague 7 (Nurse in Charge on the 14th September 2018), Colleague 8, Colleague 9 (Critical Care Outreach Nurse), Colleague 10 (the Medical Matron), Colleague 11 (Ward Manager), Colleague 12 (Interim Head of Nursing).

7. Patient A was a resident within the Female Separation and Care Unit (the "Unit") at the Prison. At around 18.00 hours on the 2nd September 2017, Patient A was concerned in an incident involving two female Prison Officers, whereby she was restrained on the floor of her cell. After which Patient A remained on the floor of her cell throughout the night. Patient A is known to have challenging behaviour towards staff and other inmates.

8. On the morning of the 3rd September 2017 staff noticed that Patient A was still on the floor. The Registrant attended the Unit to complete medication rounds at around 07.30 and was informed that Patient A had been lying on the floor all night from around 18.30 on the 2nd September 2017. The Registrant looked through the cell door observation panel and noted that Patient A was moving and breathing. The Registrant continued with her medication round and afterwards went back to Patient A's cell door observing that she could hear Patient A snoring, informing staff of this (charge 1a).

9. At around 10.50am staff were concerned that Patient A was still on the floor and called the Registrant. The Registrant, having been provided information from

staff about Patient A, indicated that she remained happy that Patient A was breathing, moving and awake, deciding that there was no need to attend the Unit. The Registrant was of the view that Patient A was "attention seeking and faking medical issues".

10. At around midday, the Registrant attended the Unit and attended Patient A's cell in order to give Patient A her medication. The Registrant again observed Patient A through the cell door observation panel and believed that Patient A had moved her position but was still lying on the floor. The Registrant indicated that Patient A was breathing and could hear snoring and decided to let her sleep (charge 1b).

11. At around 14.40, staff became concerned about Patient A's welfare and decided that medical observations were required because "alarm bells were ringing" due to Patient A's condition at that time, in that she had been lying on the floor for some considerable amount of time and that she had wet herself. As a result of these concerns, the Registrant was called to attend and was advised of the concerns that staff had in that Patient A had wet herself. The Registrant left the Tramadol Clinic and attended the Unit arriving around 14.55 (charge 1c).

12. The Registrant and staff entered Patient A's cell who was still lying on the floor at this time. The Registrant asked Patient A to get up from the floor but in response Patient A groaned at the Registrant. The Registrant continued to speak to Patient A and indicated to her that she was wasting staff's time. The Registrant went onto state, "There are residents that are really ill and they are having to wait to see me because I have got to come and see you, you need to get up, you are pathetic" (Charge 6a)

13. The Registrant then went to leave the cell but when she reached the doorway, turned, picked up a cup of water and threw it in the direction of Patient A's lower body (charge 5). At this point the Registrant is heard to say to Patient A

by a member of staff who was present, "You haven't pissed yourself, this is what you've done". Another member of staff who was also present at the time heard the Registrant say to Patient A, "you haven't wet yourself you've just done that" (charge 6b).

14. Members of staff that were present and the Registrant left the cell, with Patient A remaining on the floor. A member of staff that was present was in slight shock that the Registrant had thrown water over Patient A. The Registrant apologised to those present saying, "Sorry about that but she winds me up".

15. After briefly attending the office within the Unit the Registrant left and returned to the Tramadol Clinic. The Registrant informed the Clinical Nurse Manager that she had visited Patient A, stating that she was acting up and doing her normal tricks. This was said in a joking manner, giving the impression that everything was fine and that Patient A was just playing the fool and being silly. The Clinical Nurse Manager states that the Registrant did not give her the impression that there was any cause for concern.

16. Meanwhile, staff at the Unit were discussing the situation, concluding that the Registrant had acted unprofessionally in the manner that she dealt with Patient A. Staff agreed that they were unhappy that Patient A had been lying on her cell floor for quite some time, had wet herself and the way in which the Registrant treated her. It was decided that clinical observations were still required and so the Senior Prison Officer ("SPO") attended the Tramadol Clinic to seek a nurse to attend the Unit.

17. The SPO attended the clinic and spoke with the Registrant enquiring whether observations should be carried out on Patient A. The Clinical Nurse Manager formed the impression that the SPO was concerned that the Registrant had not carried out the appropriate observations on Patient A when she attended her cell a short time earlier. The Registrant responded to the SPO that Patient A was just

"mucking about and being her usual self". The Clinical Nurse Manager formed the impression, that when the Registrant was speaking to the SPO that there was no reason for concern, and that Patient A was fine. The SPO expressed his concerns that Patient A had been on the floor since the previous night. The Registrant offered to go back to the Unit and review Patient A.

18. It was at this point that the Clinical Nurse Manager intervened and offered to carry out observations on Patient A, because of the SPO's concerns that the previous night force was used to get Patient A back to her cell and that she had thrown herself to the floor and remained there ever since. The Clinical Nurse Manager in turn expressed her concerns to the SPO as to why none of the Prison Staff had contacted her because she was the Clinical Nurse Manager.

19. The Clinical Nurse Manager decided to go to the Unit, suggesting to the Registrant that it is probably more productive that she went over, because if Patient A was playing the fool for the Registrant, she may react differently to a different person and voice.

20. The Clinical Nurse Manager attended the Unit and the Prison Officers present were trying to convince her that Patient A was fine and just playing around. She recalls that one Prison Officer informed her that, "Patient A was fine and she had just been mucking about all night and would not get off the floor". When the Clinical Nurse Manager and prison staff got to Patient A's cell, staff were reluctant to open the cell door. However, the Clinical Nurse Manager demanded that the door be opened so that she could physically assess Patient A to confirm if there were health concerns or not.

21. The Clinical Nurse Manager entered the cell and noticed it to be in disarray, in the Patient A's belongings were all around the cell. Patient A was lying in an awkward diagonal position on her back with her head almost underneath the built in desk. Patient A had a blue hair net over her face which had a hole in the front

for her mouth and nose. Patient A's breakfast and lunch were in the cell and neither had been touched, which concerned the Clinical Nurse Manager, because it meant that a member of staff would have had to step over Patient A, who should have seen her poor condition.

22. The Clinical Nurse Manager informed staff to call for an ambulance. She recalls that Patient A's colouring and presentation did not look good and that she was very pale. The Clinical Nurse Manager formed a clear view that based on Patient A's visual presentation that she was very unwell. The Clinical Nurse Manager was talking to Patient A the whole time, trying to get her to respond. Patient A did not respond but lay there with her eyes open, staring straight up at the ceiling and fumbling with her hands. She recalls Patient A mumbling incoherently in her native language.

23. The observations recorded by the Clinical Nurse Manager at 15.15 were that Patient A had low blood pressure, unrecordable oxygen saturation levels and a blood glucose level so high that the meter could not give a reading (charge 2). She further assessed that Patient A was in diabetic ketoacidosis ("DKA").

24. The ambulance arrived very quickly and the Clinical Nurse Manager provided the paramedics a handover of Patient A. Patient A was taken to the hospital whereby she sadly died a few days later on the 6th September 2017.

25. The Clinical Nurse Manager indicated that if the Registrant had carried out the appropriate assessments of Patient A, she would have noted that Patient A was very unwell and not just "mucking about" (charge 3). She would have expected the Registrant to enter the cell and carry out physical and clinical observations to confirm whether there were any health concerns, rather than assuming that Patient A was "fine and just playing around" (charge 4).

26. The Clinical Nurse Manager does provide some mitigation on the part of the Registrant. She was of the view that Prison Staff did not take Patient A's condition seriously until it was pointed out that she was very ill. When it was pointed out that Patient A was very ill, Prison Staff began blaming the Registrant by indicating that she had not carried out the appropriate assessments. The Clinical Nurse Manager was of the view that the behaviour displayed by Prison Staff may have had some influence on how the Registrant behaved towards Patient A. However, notwithstanding these factors, the Clinical Nurse Manager would have expected the Registrant to have carried the appropriate assessments and not be influenced by the opinion of others.

27. The incident was internally investigated by the Deputy Head of Healthcare for Sodexo Justice Services and externally by NHS England who carried out a Clinical Review into Patient A's death assisted by a Senior Investigator from the Prisons and Probation Ombudsman ("PPO"). In summary, their findings were that the Registrant, at no point on the 3rd September 2017, entered the cell and carried out physical and clinical observations, by performing a "head to toe assessment" of Patient A. These observations include: checking for wounds, checking airway, and checking physical presentation (charge 2).

28. The Registrant was interviewed during both sets of investigations. When interviewed by NHS England and PPO on the 9th October 2017, the Registrant indicated that she did not enter the cell, because she feared for her safety and thought Patient A was just "playing games' or "acting up". When she did enter the cell she tried to move Patient A's leg with her foot and felt resistance. She told Patient A to stop messing around but there was no response and so she decided to throw a cup of water on Patient A to get a reaction. The Registrant stated that she did not take observations because Patient A was visibly breathing and there was nothing about her condition that "rang alarm bells", despite the fact that Patient A had been lying on the cell floor for some considerable amount of time.

29. During the course of the external investigation it was found that Patient A did have challenging behaviour but was not known to be violent.

30. When interviewed by the Deputy Head of Healthcare on the 18th October 2017, the Registrant accepted that she only observed Patient A, who had been lying on the cell floor since the previous evening, from the cell door and only entered the cell that afternoon but did not perform any observations. The Registrant also confirmed that she had thrown water over Patient A when she had entered the cell.

31. The Panel have been made aware of the death of Patient A for narrative purposes only. There is no evidence to suggest that the Registrant's failings or conduct resulted in or contributed to the death of Patient A.

32. The Registrant was suspended from her positon at the Prison on the 7th September 2017 and dismissed, as stated above, on the 30th January 2018.

33. The regulatory concerns identified in respect of the above were as follows:
- *Failure to properly conduct or record observations of Patient A.*
- *Failure to appropriately recognise and act upon the deterioration of Patient A.*
- *Uncaring and unprofessional attitude and conduct.*

34. The Registrant admits that she omitted to carry out physical and clinical observations of Patient A at the times stated in charge 1 above. The Registrant further admits that the physical and clinical observations that she should have conducted are those set out in charge 2. The Registrant further admits that by her omissions in charges 1 and 2 she failed to recognise and act upon the deterioration of Patient A, charges 3 and 4.

35. The Registrant further admits that she physically abused Patient A by throwing a cup of water over them, charge 5. In addition to this, the Registrant admits that she verbally abused Patient A as set out in charge 6.

36. The Panel should note, however, that the Registrant admits saying the following words as set out in charge 6(b), "you haven't wet yourself you've just done that" and ***not*** *"You haven't pissed yourself, this is what you've done". It is accepted by both parties that it does not matter which version, as heard by different witnesses (see paragraph 12 above), was uttered by the Registrant, because in the context of this case, both parties accept that either version amounts to verbal abuse of Patient A. In any event, either version is captured by the caveat "or words to that effect", and therefore it is not necessary for the Panel to make a finding as to which version was actually uttered.*

37. On the 14th September 2018, the Registrant was handed over the care of Patient B at the start of her shift at 08.00. Patient B was a diabetic who had the potential for DKA and at the time of the events was being administered insulin via an infusion pump and IV fluids.

38. A Consultant wrote a prescription for short acting insulin to be administered to Patient B. Colleague 8, a nurse, documented a plan of care for Patient B's diabetes, which included monitoring blood sugar levels on an hourly basis and monitoring ketone levels. Collleague 8 states that this information was verbally handed over to the Registrant, at the start of the Registrant's shift. The Registrant confirmed to Colleague 8 that she understood but indicated to Colleague 8 that she did not know how to use the insulin infusion. Colleague 8 instructed the Registrant to speak to the nurse in charge when the dose of insulin needed changing.

39. Colleague 8 states that she later reviewed Patient B in the afternoon and discovered that the Registrant had not monitored the insulin infusion or fluids

appropriately, had not administered the short acting insulin that had been prescribed by the Consultant and had not completed observations for a number of hours (charge 7).

40. Colleague 8 observed the Registrant to be crying and the Registrant informed her that, "it was her first day and she had a heavy workload". The Registrant confirmed that she had not requested help or support from the nurse in charge, Colleague 7 and this was confirmed by Colleague 7.

41. Colleague 9 who was the Critical Care Outreach Nurse working on the ward that day confirms that she reviewed Patient B at around 16.00 on the 14th September 2018. She confirms that Patient B looked unwell, their entire body appeared to be swollen and she was visibly short of breath. Patient B was not receiving any oxygen to assist with their breathing. Colleague 9 enquired with Patient B as to how they were and Patient B responded saying that she was feeling worse than she previously had (charge 9).

42. Colleague 9 took Patient B's observations and noted that no observations had been taken since early morning, around 05.00. Colleague 9 notes that Patient B's NEWS score had been 3, which meant that observations should be carried out every 4 hours. She noted that no observations had been carried out at 09.00 which was the next point in time that they should have been taken (charge 7).

43. Colleague 9 enquired with the Registrant why she had not carried out the observations on Patient B. Colleague 9 states that the Registrant was dismissive indicating that she had been busy. Colleague 9 reminded the Registrant that it does not matter about her workload and that she should be prioritising Patient B's care, as they were the most acutely unwell patient. Colleague 9 confirms that Patient B's health had deteriorated, which was missed by the Registrant as a

result of no observations taking place. Colleague 9 too confirms that the Registrant became upset and started to cry when confronted about the concerns.

44. Colleague 9 states that she recorded in Patient B's notes that observations should be taken by the Registrant on an hourly basis following her review at 16.00 and that this was confirmed to the Registrant verbally too at this time. Colleague 9 confirms that she also documented a plan of care for Patient B at this time, which was: "1h NEWS, Fluid Balance Monitoring, Cont. O2 to the target sat 94-98%, senior med review. Medications – Furosemide was already given, IVI adjusted" (charge 8).

45. Colleague 9 confirms that she reviewed Patient B on two subsequent occasions and when reviewing the observation chart, the Registrant had not followed the care plan and had not taken Patient B's observations on an hourly basis as instructed. The chart indicated that the Registrant has taken Patient B's observations at 18.45 which is nearly three hours since Colleague 9's observations at 16.00 (charge 8).

46. The Nurse in Charge on the 14th September 2018, Colleague 7 states that the Registrant, who was a Band 5 Nurse at the time, was allocated six (6) patients to care for which included Patient B. Handover took place between 07.30 and 08.00am and Colleague 7 did not recall any specific concerns relating to Patient B at that time, other than that they were a diabetic patient and was currently on a sliding scale to manage her insulin infusion and blood glucose levels.

47. Colleague 7 confirms that at no point in the morning or during the shift that the Registrant raised any concerns with Colleague 7 about her workload. Colleague 7 confirms that due to the fact that the Registrant had yet to complete her intravenous (IV) medications competency that she and other nurses on the shift assisted the Registrant with her IVs. Colleague 7 confirms that the

Registrant at no point during the shift ask for assistance or raise concerns with her, other than matters relating to IVs.

48. Colleague 7 recollects that between 15.00 and 16.00 hours that Colleague 9 approached her to enquire whether the Registrant has escalated Patient B's condition to her and whether she was aware that Patient B had been poorly or deteriorated during the shift. Colleague 7 confirmed that she was not aware of any concerns relating to Patient B. Colleague 9 informed Colleague 7 of her findings and that she had carried out observations on Patient B.

49. Colleague 7 states that Colleague 8 approached her and requested that Colleague 7 speak to the Registrant because the Registrant was upset. Colleague 7 went and spoke with the Registrant sometime between 16.00 and 16.30 hours. Colleague 7 states that the Registrant confirmed that she had been with Patient B for a lot of the shift, constantly monitoring her blood sugars but confirmed that she had omitted carrying out observations on them. Colleague 7 suggested that the Registrant take her break and to allow her to assist the Registrant with her workload. The Registrant indicated that she did not want any assistance with her workload but did agree to take her break at that time. The Registrant returned from her break and Colleague 7 indicates that the Registrant appeared to be okay and was caring for her team of patients, appearing to handle her workload well.

50. Colleague 10 who was the Medical Matron at the time of the incident, indicates that a Chief Nurse Rapid Review Meeting was held in order to establish whether the incidents were serious enough to warrant a serious incident investigation. In preparation for the meeting, Colleague 10 reviewed the clinical records of Patient B and put together a timeline of events in order to establish the Registrant's errors to be discussed at the meeting.

51. Colleague 10 established that the Registrant had not taken Patient B's observations between 08.00 and 16.00 hours. The last set of observations were taken at 05.40 hours by the night duty nurse and Patient B's NEWS was a score of 3. Colleague 10 indicates that the NEWS score will provide an indication as to how often observations should be carried on a particular patient. Colleague 10 indicates that it would have been expected that the Registrant should have carried out observations on Patient B at the start of her shift but as noted the Registrant failed to record observations from 08.00 to 16.00 hours (charge 7).

52. Colleague 10 confirms that observations were carried out by Colleague 9 at 16.00 and that observations should have taken place every hour. Colleague 10 confirms that the Registrant failed to carry out hourly observations and that the only set of observations carried out by the Registrant after 16.00 was at 18.45 hours, with the Registrant's shift ending at 20.00 hours (charge 8). Colleague 10 therefore concluded that according to the records the Registrant failed to carry out observations on Patient B between 08.00 and 16.00 hours and then hourly from 16.00 to 20.00 hours.

53. Colleague 10 noted that at 18.45 hours Patient B's health had further deteriorated with a NEWS score of 8 and the fact that the Registrant had failed to take the necessary clinical observation, resulted in a failure to recognise that Patient B's health had deteriorated (charge 9).

54. Colleague 10 noted further concerns regarding the Registrant's failure to administer medication to Patient B in a timely manner. Patient B was prescribed 4 units of insulin (Novo Rapid) at 12.50 hours which was not administered by the Registrant until 15.10 hours (charge 10). Colleague 19 notes that there were concerns regarding Patient B's high level of blood sugars and therefore determined that this medication should have been administered immediately. Colleague 10 further notes that Patient B was prescribed a further 4 units of insulin (Novo Rapid) and 17.30 but again the Registrant failed to administer this

immediately and it was delayed until 18.30 hours (charge 11). Colleague 10 states that medication should be given when prescribed.

55. The Registrant provided a statement for the purposes of the meeting detailing her account of events relating to Patient B. In summary, the Registrant stated the following:

(i) The Registrant accepts that she was in charge of Patient B's care and states that she had seen Patient B throughout the morning at regular intervals. When doing the lunchtime blood glucose tests (finger prick) Patient B had a raised BM of approximately 27+mmols. The Registrant tested Patient B's ketone levels and they were also raised. The Registrant sought the assistance [of] a Diabetic Nurse who advised the Registrant to administer a dose of insulin to which the Registrant did as prescribed by the Diabetic Nurse on the prescription chart. The Registrant states that she continued with regular BM monitoring and from memory this was every 30 mins to an hour until the end of her shift.

(ii) The Registrant accepts that she did not carry out clinical observations (on Patient B) and this was not because she could not be bothered or had forgotten but because she was prioritising the care of Patient B in an attempt to reduce blood sugar and ketone levels to prevent an episode of DKA.

(iii) The Registrant states that she apologised to Patient B for not providing appropriate care, to which the Registrant states that Patient B indicated that the Registrant had looked after her well and there was no need to apologise.

56. Following the meeting that was held on the 28th September 2018, the Registrant was suspended on this date, pending an internal investigation.

57. Colleague 11, a Ward Manager at the Hospital, was informed on her return from annual leave of the incident involving the Registrant and the incident was

recorded as a Grade 3 Datix, which meant that moderate harm had occurred. Colleague 11 confirms that because of the Grade 3 Datix the incident was made the subject of a Meeting (as highlighted above at paragraph 49). Colleague 11 met with the Registrant on the 25th September 2018 confirming that a Datix had been raised and requested the Registrant to provide a written statement (as mentioned in paragraph 53). The Registrant was placed on supervised practice and was not to complete observations or administer medication pending the outcome of the meeting.

58. Colleague 11 confirms that she met with Colleague 10 to go through the documentation prior to the meeting preparing a timeline of events concerning Patient B.

59. Colleague 11 confirms that the meeting took place on the 28th September 2018 and did not take part in the meeting. Colleague 11 confirms that the Registrant was thereafter suspended pending a formal investigation and Colleague 11 confirms that she headed this investigation. Colleague 11 confirms that in order to investigate the incident, she reviewed Patient B's clinical records (including the care plans, observation charts, diabetes charts and medical notes) and interviewed: Colleague 8 on the 8th February 2018, Colleague 9 on the 8th February 2018, Colleague 7 on the 22nd February 2018 and the Registrant on the 22nd February 2018. In summary, the Registrant stated the following:

(i) That she was aware of the Diabetes Care Plan created at 12.30pm for Patient B and as far as she was aware followed the plan.

(ii) The Registrant was shown Patient B's chart and accepted that there was a delay in treatment, which the Registrant states was down to her workload and that she had another very poorly patient that required her care.

(iii) The Registrant was asked about the insulin (Nova Rapid) to be administered at 12.50pm and whether she administered it at this time. The Registrant accepts that she did not at that time. The Registrant stated that the Diabetes Nurse prescribed the dose and was going to complete the chart, but the Registrant did this but only when she got round to seeing the patient again not specifically at the time it was given.

(iv) The Registrant was asked why she had not administered the insulin until 15.10. The Registrant stated that she thought the nurse would come round and find her once it was done but she didn't.

(v) The Registrant was asked whether she administered a further 6 units of insulin at 17.30 and the Registrant indicated that she could not remember. The Registrant states that Patient B may have been eating at the time and this may have been the reason for the delay but the Registrant stated that she could not honestly say that this was the reason as she cannot remember.

(vi) The Registrant indicated that she has had diabetes training but this related to pens and monitors and that no one had been given training before the wards changed. The Registrant stated that she had not completed her medical device training.

(vii) The Registrant was asked questions relating to observations of Patient B and was shown the observations charts. The Registrant did not notice that Patient B was short of breath having spent time with the patient taking her to a lot of toilet breaks.

(viii) The Registrant was asked why she had not taken observations from 07.30 to 16.00. The Registrant accepted that they required to be completed but she did not have a HCA to assist her and that she had another patient on insulin at the time. The Registrant states that she did not forget to do them but was delayed

with other work. It was her first day on the new ward which was chaotic. She accepts that she should have spoken to the nurse in charge.

(ix) The Registrant was asked whether she was aware of the Plan for hourly observations and whether she followed this plan. The Registrant indicated that she could not remember but if was made aware of it but if she was then she would have followed the Plan.

(x) The Registrant was shown the chart indicating that hourly observations were not carried out and asked why there was a delay. The Registrant said that she honestly cannot say as she did not remember.

(xi) The Registrant was asked how the shift was. The Registrant stated that it was very chaotic, that she was not given any training before going onto the ward, that she had a large workload and that the shift wasn't a good one. The Registrant went onto say that it was her first shift on a new ward and had a mixture of patients including surgical. She felt exhausted by the end of the shift.

(xii) The Registrant went onto to say that she did apologise to Patient B for not giving her the care that she deserved but Patient B did not have any complaints. The Registrant went onto say that she had carried out observations on all the other patients. The Registrant indicates that she had no breaks, no lunch, no one to take over and no HCA. She states that she felt isolated but just wanted to get on with her work as her patients come first. She accepted that she did not ask for help other than in relation to IVs. The Registrant indicates that she did ask for help in areas that she was not trained in doing, IVs. When asked if needed more support the Registrant said that she did and knew that she could ask for more help that day which she did not do.

60. Colleague 11 confirms that the Registrant failed to undertake clinical observations for Patient B and in doing so failed to follow NEWS protocols. From

16.00 hours the Registrant failed to provide care in accordance with Patient B's care plan which caused delay in recognising Patient B's deterioration and subsequent delay in an escalation of care. Furthermore the Registrant failed to follow the care plan from the Diabetic Nurse by providing insulin within the appropriate time scale (charges 10 and 11). Especially in the knowledge whereby the Registrant was aware that that there were issues relating to Patient B's blood sugar / ketone levels.

61. No harm was caused by the Registrant's omissions and Patient B was later discharged. Patient B was not an elderly patient.

62. Colleague 11 acknowledges that in mitigation the incidents occurred in the Registrant's first shift on Plum Tree Ward. The Registrant was previously on a different ward (Cherry Tree Ward) whereby patients were non-acute/elderly patients, whereas on Plum Tree Ward patients were acutely unwell. Colleague 11 acknowledges that Colleague 9 indicated that staff were offered very little support and no training was provided on the new speciality prior to commencing shifts on Plum Tree Ward and as a result staff were left to care for patients that they were unfamiliar with. Colleague 9 provided an example whereby nurses had to look after younger acutely unwell patients who become unwell and who present visual symptoms differently to elderly patients, where it is much easier to spot deterioration visually.

63. Colleague 11 confirmed that the Registrant had not had all of the appropriate training prior to working on the Ward in a new speciality. This was confirmed by Colleague 7 when interviewed by Colleague 11. Colleague 7 stated that the first few shifts were very confusing and that all staff felt confused. Colleague 7 stated that the shift was very busy and that the new Ward lacked structure. Colleague 7 went onto state that staff were also unaware of how to properly care for patients on the Ward since it was a new speciality.

64. Following the investigation, Colleague 12 (Interim head of Nursing) confirms that the Registrant was downgraded to a HCA and was redeployed to the Medical Short Stay Unit.

65. The Regulatory concerns identified and investigated by the NMC are as follows:

• Failure to conduct adequate observations, administer medication and identify deterioration in relation to Patient B

66. The Registrant admits that she failed to carry out the observations as set out in charges 7 and 8 and by doing so admits that her omissions meant that she failed to recognise Patient B's health was deteriorating.

67. The Registrant further admits that she should have administered the insulin (Novo Rapid) upon it being prescribed and delayed the administration of it (charges 10 and 11). The Registrant accepts that she should have been aware of the importance of administering the insulin immediately having been aware of issues surrounding Patient B's blood sugar and ketone levels during the shift.

68. The Registrant accepts that although the Registrant was new to the Ward, was over loaded and was unfamiliar with patients of this nature, she failed to prioritise Patient B's care and request assistance when needed.

69. In addition to its own investigation the NMC received and assessed all of the relevant evidence obtained from outside investigations. The Registrant does not dispute the contents of that evidence, as investigated by the NMC.

70. To confirm, the Registrant accepts the charges are a full reflection of the evidence and accordingly makes admissions to them.

71. The Registrant has been engaging with the NMC process.

Misconduct

72. In the case of Roylance v General Medical Council (No.2) [2000] 1 AC 311, Lord Clyde stated that:

"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by the medical practitioner in the particular circumstances".

73. The Registrant's conduct fell seriously short of the standards of behaviour expected of Registered Nurses. Moreover, the Registrant's actions breached the following paragraphs of the 2015 NMC Code of Conduct:

1 Treat people as individuals and uphold their dignity
To achieve this you must:
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively
1.3 avoid making assumption and recognise diversity and individual choice
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
1.5 respect and uphold people's human rights

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this you must:
3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

7 Communicate clearly

To achieve this you must:

7.1 use terms that people in your care, colleagues and the public understand

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to peoples personal and health needs

7.5 be able to communicate clearly and effectively in English

8 Work co-operatively

To achieve this you must:

8.1 respect the skill, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

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 a person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

74. Although it is not suggested, in the case of Patient A that the Registrant's conduct resulted or contributed to the death of Patient A, the conduct displayed would have had the potential of causing significant harm to them. The Registrant's actions as set out in charges 5 and 6 had the potential of causing psychological harm to Patient A, in the absence of any physical injury.

75. In respect of Patient B, a failure to carry out the appropriate observations and administer medication in a timely manner, again had the potential of causing significant harm to Patient B. It is rather fortunate that, due to the Registrant's omissions, there was no actual harm caused to Patient B, notwithstanding the Registrant's inability to assess that Patient B's health was deteriorating.

76. The Registrant accepts that being a nurse, her primary role is to provide care to those who are vulnerable and to those who are in need of care. The Registrant accepts that, as a registered nurse, she must practise effectively and safely in order that patients are not placed at significant risk of harm. The Registrant accepts that maintaining health and safety of patients is considered a vital component of high quality nursing care. The Registrant accepts that the conduct displayed in both incidents is a serious departure from those standards and exposed patients to a risk of serious harm.

77. The Registrant further accepts that kindness and compassion are fundamental principles of nursing care. The Registrant accepts that her conduct as displayed towards Patient A was a serious dereliction of this principle. In addition the Registrant accepts that her conduct in charges 5 and 6 demonstrates underlying attitudinal behaviour that is difficult to remediate. The Registrant further accepts that the words said in charge 6 amount to a verbal abuse of Patient A and is regarded as being serious misconduct.

78. The Registrant accepts that in the case of Patient A, she should have undertaken the appropriate clinical observations and by not doing so is a departure of a primary role to care for those in need. The Registrant accepts that she should have acted independently of those around her, and any possible negative influences from those present, putting aside any negative assumptions towards Patient A and recognised that they were in need of immediate care. The Registrant accepts that by not carrying out her primary duty as a nurse she failed in her duty of care towards Patient A by not appropriately assessing Patient A and her surrounding circumstances at the times when requested.

79. The Registrant also accepts that she failed in her duty of care towards Patient B by not carrying out the appropriate clinical observations as requested. Notwithstanding contextual factors, such as, it being a busy shift, a new Ward with different patient needs, and workload, the Registrant accepts that she should have prioritised Patient B's care, knowing that there were issues surrounding Patient B's blood sugar and ketone levels.

80. The Registrant further accepts that she should have administered the insulin when prescribed, prioritising Patient B's care before moving onto the care of another patient. The Registrant accepts that her failure to administer the medication for a second time is an aggravating aspect of her failure in the duty of care towards Patient B.

81. The Registrant accepts that her actions damage the trust members of the public have with the profession and the NMC as its regulator and as such accepts that, in light of the these factors, her conduct has fallen far below the standards expected of a registered nurse, breaching fundamental tenets of the profession.

82. The Parties therefore accept that the facts as set out amount to serious misconduct.

Current Impairment

83. The Parties have considered the questions formulated by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of CHRE v Grant & NMC [2011] EWHC 927 (Admin) ('Grant') by Cox J. They are 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

84. The Parties agree that the above limbs are engaged in this case. A nurse failing in their duty of care towards patients is a dereliction of that duty, which not only places patients at significant risk of unwarranted harm, but also breaches fundamental tenets of the profession thereby bringing the profession into disrepute. Maintaining the health and safety of patients, acting with kindness and compassion are fundamental values of the nursing profession which must be maintained at all times, irrespective of any contextual factors that may be present in this case.

85. In considering the question of whether the Registrant's fitness to practise is currently impaired, the Parties have considered Cohen v GMC [2007] EWHC 581 (Admin), in which the court set out three matters which it described as being 'highly relevant' to the determination of the question of current impairment:

(a) Whether the conduct that led to the charge(s) is easily remediable?
(b) Whether it has been remedied?
(c) Whether it is highly unlikely to be repeated?

86. The Parties agree that the attitudinal conduct displayed by the Registrant, in respect of Patient A is regarded as being difficult to remediate. The positive aspect is that the Registrant has always accepted that she threw water over Patient A and although the Registrant has not specifically touched upon those comments made within charge 6, she has accepted that her behaviour that day towards Patient A, fell below the standards expected of a professional nurse.

87. The Registrant has shown regret and remorse for her conduct in respect of Patient A. In addition, the Registrant has shown insight into her conduct and acknowledges that her fitness to practise is currently impaired. This provides a sufficient indication that the attitudinal conduct can be remedied.

88. Although the attitudinal conduct was very serious, it was an isolated incident whereby the Registrant suggests that she has learned from her mistake. The Registrant has shown an understanding that her role as a nurse is paramount and that she should not have been influenced by Patient A's previous known behaviour or concerns about entering the cell (see appendix A attached: Registrant Reflective Statement dated 23 March 2021). The Registrants states the following in her reflective account:

On reflection, I made too many assumptions on the day in question. I failed to ask the operational staff through the day how Patient A appeared to be

presenting. I should have attempted to conduct clinical observations on Patient A. This would have enabled me to make my own informed decision surrounding her condition. I failed to react in a timely or appropriate manner to ensure the wellbeing of Patient A.

During and following the incident on 03.09.2107 I have experienced a range of feelings and emotions, frustration at Patients A's behaviour, as I perceived it, and her lack of acknowledgment towards me, appearing to deliberately ignore me. I felt apprehensive about entering her cell as she may have attempted to behave as she had done the previous evening by grabbing at the legs of staff. Subsequently, following the events of the 03.09.2017, I have had time to reflect on my behaviour toward Patient A. Had I witnessed another nurse do the same to a patient, I would have felt shocked and upset by their actions. My thoughts and actions on the day of 03.09.2107 were based on Patient A's previous behaviours which allowed my perceptions of her to be masked by the real picture. I wrongly made assumptions and focused too intently on those behaviours. I believed on the day that Patient A was acting at being unwell. This led to me having no cause for concern on that day regarding Patient A, as I did not see or feel that anything appeared to be unusual or physically wrong with Patient A. However, it turned out that this was not the case and Patient A's health deteriorated over the course of the day, ending in her death a few days later in hospital.

Even if it turned out that the patient had not been unwell, I should have undertaken my own clinical assessment and observations, which would have allowed me to make an informed decision on how to respond and be sure that there was no cause for concern. My actions on that day fell below the NMC code of conduct 2018, the standards expected of a registered nurse, from staff by Sodexo Justice Services (SJS), as well as the standards I expect of myself. This was not typical of my normal standard of work and behaviour. I deeply regret not seeing how unwell Patient A had become and for my unprofessional and

unacceptable conduct towards her. I am extremely ashamed and embarrassed for treating her so uncaringly and at a time when she was most in need. I will always carry the guilt with me for not intervening earlier in Patient A's welfare and for not recognising how unwell she had become. It would be easy for me to blame external factors, however there is no excuse for the way I behaved towards Patient A on that day and only I am accountable for my actions or non-actions. I would like to offer my most sincere apologies to all concerned, most importantly to Patient A and their family".

89. The Registrant goes onto state:

"As a nurse I should always act in the best interest of my patients, and act to preserve their dignity. On 03.09.2017 I failed to act in the best interest of Patient A, I failed to treat and preserve her dignity. Throwing water onto Patient A's abdomen is not a recognised form of non-invasive stimuli within the nursing profession and is not upheld by the NMC and had the potential to cause distress and emotional upset to the patient, as well as bringing the profession into disrepute. I failed to value Patient A as an individual. I failed to give treatment, assistance and care to Patient A in a timely manner. I made assumptions regarding Patient A and her behaviour on that day and for this I apologise unreservedly for my conduct towards her.

For both instances I apologise unreservedly to the patient, their family and all concerned and I seek to reassure the NMC that this was out of character for me and will never be repeated".

90. The Parties agree that because the Registrant has not practised as nurse since being referred to the NMC, she has been unable to remediate her conduct whilst practising as a nurse. Although, the Registrant was working as a HCA, dealing with patients and colleagues, with no suggestion that the attitudinal conduct has been repeated, it cannot be stated with confidence that until properly

assessed, the Registrant has sufficiently demonstrated the ability to refrain from such conduct within a busy hospital and/or prison environment whilst practising as a nurse.

91. The Registrant has shown insight into her failure to conduct clinical observations of Patient A and failing to act on Patient A's deterioration. The Registrant stated the following:

"The impact of not keeping accurate and up to date records had the potential to mislead my colleagues in to believing that I may not have seen Patient A at all during 03.09.2107. My failure to conduct clinical observations as well as my failure to document that I had visually observed Patient A meant there was no accurate and up to date recorded information of Patient A's health on that day. I should have recorded my visual observations, even if there appeared to be no cause for concern. As a student nurse I was always taught that 'if it is not written down it did not happen'. My lack of documentation failed to highlight that I had seen Patient A and had no concerns at the time, however I realise how important it is to keep accurate, timely records to enable all staff involved in the care of a patient to be able to easily refer to the patient notes and gain information required for the timely intervention of any treatments or procedures that may need to be performed or any medications that may need to be administered, thus reducing the potential for further deterioration of a patient's health.

As a nurse I am accountable for my own actions in practice. I should always put the patients' interests first and ensure that I am always open and honest in any record keeping. (Nursing and Midwifery Council (NMC) Code of Conduct 2018). My failure to conduct clinical observations on Patient A and recognise how unwell she had become throughout the day was unprofessional and unacceptable. As a registered nurse I should have been able to identify any deterioration and act upon it. I should not have allowed my assumptions to cloud my judgement and prevent me from providing the appropriate duty of care to Patient A".

*92. The Registrant has demonstrated insight into her failings relating to Patient B, with mitigating circumstances. In particular the Registrant has stated the following (see **appendix A** attached: Reflective Statement):*
"I failed to carry out clinical observations in a timely manner, my omission was somewhat due to this being my first day on Plum Tree Ward and the unfamiliarity with its operation and workload. However, I should have highlighted to the nurse in charge, at the start of the shift that I would require extra support while I found my feet and adjusted to the ward. Following handover, I had already arranged for my colleagues to help with the preparation and administration of IVs and assistance with some of the medical equipment which I had not received training on. I did not want to impose on them anymore than was necessary as they had their own workloads to deal with. I felt that if I requested anymore support, I would be overburdening my colleagues and the nurse in charge, who had their own tasks to attend to. However, had I alerted the nurse in charge earlier in the day to my struggling with the workload she may have been able to assist me".

"Prior to moving to Plum Tree ward there had been no formal training in the specialities of the ward for any of the staff. The lack of training posed a high risk for error. I had been looking forward to the challenge of a new ward, however I found myself feeling quite anxious about the move, although many of the staff from Cherry Tree Ward would also be moving over it was still quite daunting to start again. I was aware during the shift that I needed to carry out clinical observations on my patients, however I was unable to complete them in a timely manner and I offer my apologies to all concerned. I felt, due to my circumstances, that I had to prove myself not just to my colleagues but also to myself. I now realise that I had nothing to prove and to ask for help throughout the shift would not have been a sign of weakness, in fact it would have shown insight that I needed help".

“My failure to carry out clinical observations and administer medication in a timely manner could have had a detrimental effect on Patient B. There was no intention to cause harm, but I had not at that point been able to get them completed, which unintentionally could cause harm to patient B. I should have recognised earlier that I needed to ask for help, however I did not as I felt that I had to prove myself to others as well as myself. In retrospect this was totally the wrong way to handle the situation as it could put patients at risk. As I did not perform clinical observations in a timely manner, I failed to see that Patient B had deteriorated during the afternoon, I had not seen that she was becoming short of breath and for that I apologise unreservedly”.

“I fully acknowledge that there are similarities to the incident relating to Patient A, where I failed to carry out clinical observations in a timely manner. In relation to the delayed insulin administration, I placed Patient B at risk of developing DKA through my error and could have resulted in her having an extended hospital stay. However there are differences with both incidents in that with Patient A I allowed my judgement to be clouded by her previous behaviours, whereas with Patient B, I was struggling to adjust to my first day on the new ward, where it has been acknowledged that there was a lack of training and support for all new staff on the ward. I was failing to manage the new workload and my anxiety was increased due to fear of failure and things going wrong whilst still on an interim conditions of practice order. At the time I was fearful that I would be seen as not being able to manage the work which, I felt, could come with repercussions, and this slowed me from seeking support. It is clear to me now that asking for help would have been the right thing to do here and would have been in the best interests of my patients, as by not asking for help I was already failing my patients, as in line with the NMC code (2018) in relation to preserving patient safety and exercising my professional duty of candour”.

“I placed patient B at risk by, unintentionally, delaying her insulin and the consequences that could have arisen due to the delay. The delay in

administering the insulin could have caused Patient B to develop Diabetic Ketoacidosis (DKA), this is where the body starts to run out of insulin and ketones build up in the body. DKA is life threatening for people with Insulin Dependent Diabetes Mellitus (IDDM), or Type 1 Diabetes. When ketones build up the body reverts to breaking down the fat to convert to energy, as it is unable to convert glucose for energy, causing ketones to be released into the body, if not dealt with quickly the build-up of ketones causes the blood to become acidic. DKA has the potential to cause low levels of potassium, swelling inside the brain, fluid inside the lungs and damage to the kidneys or other organs due to fluid loss, this can lead to muscle weakness and heart rhythm problems, cerebral and pulmonary oedema that could result in death. (www.nhs.uk) (www.cedars-sinai.org) (www.diabetes.org.uk)"

"I have learnt from this experience that asking for help is not a sign of weakness, it may be viewed more as a sign of strength, and it is definitely the correct course of action when patients and the nursing profession could be affected. Not only that, but also it would have reduced my anxiety and stress levels as an individual, allowing me to work at a greater capacity. There is no shame in admitting that you are struggling and need help, especially when other peoples' safety and my colleagues' reputations are at risk. I could also have flagged up earlier to senior staff that the preparation had not been sufficient for many staff who were also new to the ward, including the absence of a ward manager during the first two weeks of the ward. This may have helped to have made the first day on the ward a much smoother transition for myself and many of my colleagues".

"My actions on 14.09.2018 had the capacity to cause harm to Patient B and extend their stay in hospital as well as bring the nursing profession into disrepute, including the reputation of the National Health Service and the hospital. I take full responsibility for my actions on the day in question. I fully understand that two incidents of failing to undertake clinical observations may cause concern for the NMC in relation to my practice as a registered nurse. I hope I have demonstrated

to the NMC that I have worked hard to understand the reasons behind both incidents, and my accountability in each of them. This personal understanding and examination of where I went wrong, and what I could have done better has helped me to develop further as both a nurse and person. I would like to offer my sincere apologies to everyone concerned, especially Patient B".

*93. The Registrant has also demonstrated insight with regards her failings taking into account the NMC Code (see **appendix A** attached: reflective statement). In addition the Registrant demonstrated remediation through training that she has undertaken (again see **appendix A** attached: training certificates attached). The Registrant has demonstrated and identified through the training that she has completed, where she went wrong and identifying how she would approach situations of a similar nature in the future.*

*94. The Registrant has provided positive testimonials demonstrating the Registrant's progression since the incidents occurred (see **appendix A** attached).*

95. In summary the parties agree that until the Registrant practises as a nurse, the failings in this case have not been fully remediated.

Impairment - public protection

96. The Parties agree that although the Registrant has demonstrated insight into her failings, the fact that they have not yet been fully remedied and that there are similarities between the incidents there remains a risk of the concerns being repeated in the future.

97. The Parties agree that in these circumstances a finding of current impairment is necessary on public protection grounds.

Impairment – public interest

98. The full seriousness of the regulatory concerns has been identified and is accepted by the Parties. The misconduct involves serious breaches of fundamental tenets of the profession, in particular a nurse's fundamental duty of care to patients.

99. Accordingly the Parties agree that this is a case where a finding of current impairment is also required to declare and uphold proper professional standards and protect the reputation of the nursing profession, in accordance with the comments of Cox J in Grant at paragraph 101:

"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case."

100. The Parties therefore agree that a finding of current impairment is required on public interest grounds.

101. The Parties therefore agree that the Registrant's fitness to practise is currently impaired on the suggested grounds.

Sanction

102. The parties agree that the proportionate sanction in this case is a Condition of Practice Order for a period of 18-months with a review prior to expiry. The Parties considered the NMC Sanctions Guidance, bearing in mind that it provides guidance not firm rules.

103. The aggravating features of the case are as follows:

- *Serious failure to undertake clinical observations for Patient A and Patient B*
- *Verbal and physical abuse of Patient A*
- *Similarity of clinical incidents regarding Patient A and Patient B*
- *Patient A and Patient B were extremely vulnerable*

104. The mitigating features of the case are as follows (not exhaustive):

- *Remorse demonstrated*
- *Insight / Reflection demonstrated*
- *Undertaken further training relating to the failings*
- *Positive testimonials*
- *Admissions made and engaged throughout the process*

105. The Parties considered the appropriate sanction, starting with the least restrictive sanction.

106. The Parties agreed that taking "no further action" would be inadequate deal with the public protection and public interests grounds in this case. The failings are too serious and as such this sanction would not be proportionate or appropriate.

107. The Parties agreed that imposing a Caution Order would be again be inadequate to deal with the public protection and public interests grounds in this case. It would be insufficient to protect the public whilst the Registrant undertakes to remediate her failings and therefore is not proportionate.

108. The Parties then considered a Conditions of Practice Order. The Parties agree that this sanction would be proportionate to deal with the public protection and public interest concerns. The Registrant has demonstrated insight into her

failings but has yet been unable to fully remediate the concerns, working as a nurse. There are workable conditions that could be imposed to safeguard against any risk to the public, such as supervision and personal development plans and as such would allow the Registrant to demonstrate in practice that she is capable of remediating the concerns in this case. The Panel is invited to consider the NMC guidance and compendium as to the workable, proportionate and appropriate conditions to impose. The Parties agree that the following conditions are appropriate, proportionate and workable:

For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must limit your nursing practice to employment in a substantive post.

2. You must keep us informed about anywhere you are working by:
a. Telling your case officer within seven days of accepting or leaving any employment.
b. Giving your case officer your employer's contact details. Page 30 of 33

3. You must ensure that you are supervised at any time you are working. Your supervision must consist of:
• Working at all times on the same shift as, but not always directly observed by another registered nurse.

4. You must meet with your line manager/supervisor/mentor every month to discuss your clinical competence and professional conduct.

5. You must provide a report from your line manager/supervisor/mentor to the NMC before 4-weeks prior to the review of the Substantive Order commenting on your clinical competence and professional conduct.

6. You must keep us informed about anywhere you are studying by:
a) Telling your case officer within seven days of accepting any course of study.
b) Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:
a) Any current or future employer.
b) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

8. You must tell your case officer, within seven days of your becoming aware of:
a) Any clinical incident you are involved in.
b) Any investigation started against you.
c) Any disciplinary proceedings taken against you.

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
a) Any current or future employer.
b) Any educational establishment.
c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

109. Furthermore, although there are attitudinal concerns relating to the Registrant's conduct relating to Patient A, it cannot be said that these concerns are deep-seated in nature. The Registrant has shown full insight into her conduct, which the Parties agree was mitigated, albeit wrongly, by assumptions

the Registrant made in respect of Patient A. The evidence suggests that this was an isolated incident and the Registrant has shown sufficient remorse to indicate that the risk of this behaviour being repeated is low.

110. A Conditions of Practice Order would mark the seriousness of this case and would adequately protect the public and meet the public interests.

111. Suspension order: The Registrant's misconduct does raise fundamental concerns around her role as a nurse. But taking into consideration the above, temporary removal, although providing protection to the public as the Registrant would be prevented from practising as a nurse, would be disproportionate. As stated the Registrant has demonstrated significant insight into her wrongdoing, has an understanding of what went wrong and what she would do differently in the future. Therefore, a sanction of this nature could be regarded as being disproportionate in the circumstances of this case.

112. Given the serious nature of the misconduct in this case, most notably the Registrant's lack of compassion towards Patient A, the Parties agree that a Conditions of Practice Order can be regarded as the most appropriate and proportionate sanction to impose. It provides sufficient safeguards to protect the public and it addresses the wider public interest.

113. The Parties agree that the proposed sanction has taken into consideration the aggravating and mitigating factors in this case.

114. A Conditions of Practice Order will address any risk of the conduct being repeated and is sufficient to maintain professional standards. The sanction will ensure that public confidence in the profession is maintained. Further, it will allow an additional period time for the Registrant to obtain a role as a nurse and to fully remediate her failings.

115. The parties agree that a review of a Conditions of Practice Order is necessary to enable a future panel to properly assess whether the Registrant has fully remediated the concerns.

116. In relation to a striking-off order the parties agree that the Registrant's conduct cannot be regarded as being fundamentally incompatible with continues registration and, taking into account the Registrant's admissions, remorse, insight and training undertaken the serious features of the case can be appropriately recognised by the imposition of a Conditions of Practice order. Therefore the parties agree that striking the Registrant from the Register would be disproportionate in the circumstances of this case.

Interim Order

117. Finally, the Parties agree that an interim order is required in this case. The order is necessary for the protection of the public and is otherwise in the public interest. The order should be for a period of 18 months to guard against the risk to the public in the event that the Registrant seeks to appeal against the substantive order. The interim order should take the form of an interim conditions of practice order with conditions mirroring those of the substantive order.

118. The Parties understand that this provisional agreement cannot bind a panel, and that the final decision on final decision on findings impairment and sanction is a matter for the panel. The parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted pane that is determining the allegations, provided that it would be relevant and fair to do so'.

Here ends the provisional CPD agreement between the NMC and Mrs Watts. The provisional CPD agreement was signed by Mrs Watts on 12 April 2021 and the NMC on 13 April 2021.

Decision and reasons on the CPD

The panel decided to accept the CPD.

The panel heard and accepted the legal assessor's advice. Ms Knight referred the panel to the 'NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. She reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Mrs Watts. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel noted that Mrs Watts admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of Mrs Watts's admissions, as set out in the signed provisional CPD agreement.

Decision and reasons on impairment

The panel then went on to consider whether Mrs Watts's fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Mrs Watts, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of misconduct, the panel agreed that Mrs Watt's conduct fell seriously far below the standards expected of a registered nurse. She had the duty of care to the patients under her care and was expected to provide adequate diagnosis, support, show kindness and compassion. It also considered that the areas of the Code that had been identified by the NMC were appropriate. In this respect, the panel endorsed paragraphs 72 to 82 of the provisional CPD agreement in respect of misconduct, whilst correcting the errors in paragraphs 79 and 80 which wrongly refer to Patient A rather than Patient B.

The panel then considered whether Mrs Watts' fitness to practise is currently impaired by reason of her misconduct. The panel determined that Mrs Watts' fitness to practise is currently impaired. The panel considered that her actions clearly put patients at unwarranted risk of harm, specifically Patient A and Patient B. The panel took into account that the reference to Patient A's subsequent death was for narrative purposes only and that there was no suggestion that Mrs Watts' actions or inactions were a contributory factor.

The panel considered the guidance by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of *CHRE v Grant & NMC [2011] EWHC 927 (Admin) ('Grant') by Cox J*.

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 determined that the above three limbs as identified in the case of Grant have been engaged.

The panel determined that Mrs Watts' misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find Mrs Watts' fitness to practise impaired in circumstances where she has admitted to the facts of this case.

Regarding insight, the panel had regard to the reflective statement, training and testimonials provided by Mrs Watts. It noted that Mrs Watts had made admissions, shown remorse for her actions and had demonstrated an understanding of where she went wrong and able to identify how she would approach the situation in the future, how this impacted negatively on her colleagues and on the reputation of the nursing profession. The panel was therefore satisfied that Mrs Watts had demonstrated insight into her misconduct.

With regard to remediation, the panel bore in mind that Mrs Watts has been working as a Health Care Assistant and has not worked as a Registered Nurse since the NMC investigation in 2018. The panel therefore determined that there remains a risk of repetition and a consequent risk of unwarranted harm to patients, and therefore potential damage to the reputation of the nursing profession if a finding of impairment were not made. It determined that a finding of current impairment was necessary on public interest grounds to maintain public confidence in the profession and to declare and uphold proper professional standards. In this respect the panel endorsed paragraphs 83 to 101 of the provisional CPD agreement.

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/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. It determined that a fully informed member of the public would be appalled by Mrs Watts' misconduct, and

extremely concerned should a finding of no current impairment be made in light of her actions.

Having regard to all of the above, the panel was also satisfied that Mrs Watts' fitness to practise as a registered nurse is currently impaired on public protection and public interest grounds.

Decision and reasons on sanction

Having found Mrs Watts' 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 SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account and agreed the aggravating and mitigating factors as presented in the CPD. It agreed that these were appropriate. It also noted the comments in the CPD in relation to the attitudinal concerns and was in agreement that it was a one off incident and took place while Mrs Watts was in a new work environment.

The panel took into account the following aggravating features:
• Serious failure to undertake clinical observations for Patient A and Patient B
• Verbal and physical abuse of Patient A
• Similarity of clinical incidents regarding Patient A and Patient B
• Patient A and Patient B were extremely vulnerable.

The panel also took into account the following mitigating features:
• Remorse demonstrated
• Insight / Reflection demonstrated
• Undertaken further training relating to the failings

• Positive testimonials
• Admissions made and engaged throughout the process.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Watts' practice would not be appropriate in the circumstances. The panel considered that Mrs Watts' misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 Mrs Watts' 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 Mrs Watts would be willing to comply with conditions of practice, has shown insight and remorse for her actions and made early admissions, has remained in employment within the healthcare sector, has provided positive testimonials, and has undertaken training to address the areas of concern. Mrs Watts has engaged with the NMC since the referral and it has been confirmed that there have been no adverse findings in relation to her practice before and after these incidents.

The panel had regard to the fact that these incidents happened a long time ago and that, other than these incidents, Mrs Watts has had an unblemished career as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, Mrs Watts should be able to return to practise as a nurse. In making this decision, the panel had regard to the public interest of allowing a competent nurse to resume practice.

Balancing all of these factors, the panel agreed with the CPD 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 Mrs Watts' case.

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 agreed with the CPD that the following conditions are appropriate and proportionate in this case:

For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must limit your nursing practice to employment in a substantive post.

2. You must keep the NMC informed about anywhere you are working by:
   a. Telling your case officer within seven days of accepting or leaving any employment.
   b. Giving your case officer your employer’s contact details.

3. You must ensure that you are supervised at any time you are working. Your supervision must consist of working at all times on the same shift as, but not always directly observed by another registered nurse.

4. You must meet with your line manager/supervisor/mentor every month to discuss your clinical competence and professional conduct.

5. You must provide a report from your line manager/supervisor/mentor to the NMC before four weeks prior to the review of the substantive order commenting on your clinical competence and professional conduct.

6. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:
   a) Any current or future employer.

b) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

8. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 18 months.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mrs Watts has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Decision and reasons on interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Watts own interest until the conditions of practice sanction takes effect.

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

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 agreed with the CPD 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 adequately cover the 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 Mrs Watts is sent the decision of this hearing in writing.

That concludes this determination.