Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 16 August 2021 – Thursday, 19 August 2021

Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Ayisha Amoah
NMC PIN:	14A1844E
Part(s) of the register:	Registered Nurse – Sub-part 1 Adult Nursing – 3 December 2014
Area of registered address:	London
Type of case:	Misconduct
Panel members:	Andrew Harvey (Chair, Lay member) Alex Forsyth (Lay member) Laura Scott (Registrant member)
Legal Assessor:	Ian Ashford-Thom
Panel Secretary:	Philip Austin
Nursing and Midwifery Council:	Represented by Jessica Bass, Case Presenter
Registrant's name:	Present and represented by Kate Parker, counsel, instructed by Blackfords LLP
Facts proved:	All charges
Facts not proved:	None
Fitness to practise:	Currently impaired
Sanction:	Caution order – 3 years
Interim order:	None

Details of charge

That you, a registered nurse, on 22 January 2019;

1) Altered Patient A's prescription for Oxycodone from 7.5mg to 10mg.

2) Your conduct in Charge 1, above, was dishonest in that you knew Dr 1 had prescribed 7.5mg of Oxycodone to Patient A but intended to create the misleading impression that 10mg had been prescribed.

3) Administered 10mg of Oxycodone to Patient A when you knew that Dr 1 had prescribed 7.5mg.

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

NMC Opening

The NMC received a referral in relation to your nursing practice from Kings College Hospital NHS Foundation Trust ("the Trust") on 28 March 2019. At the time of the alleged events, you were working in the Haematology Outpatients Department ("the Department"), having been employed as a Band 6 Senior Staff Nurse in the Outpatients Supportive Therapy at the Trust.

It is alleged that on 22 January 2019, you asked Dr 1 to prescribe 10mg of Oxycodone to Patient A, with you having spoken to the Clinical Nurse Specialist, Ms 2, who advised that a dose of 10mg of Oxycodone should be prescribed.

Dr 1 checked Patient A's care plan and noted that a 7.5mg dose of Oxycodone should be administered to Patient A. Dr 1 was allegedly reluctant to deviate from the care plan and prescribed 7.5mg of Oxycodone for Patient A.

Later that evening, Dr 1 was allegedly searching for a drug chart for another patient when she came across the prescription she had written for Patient A. It is alleged that Dr 1 believed that this prescription had been tampered with, as the prescription read that 10mg of Oxycodone had been prescribed, when she knew she had only prescribed 7.5mg.

It is therefore alleged that you had dishonestly altered Patient A's prescription of Oxycodone from 7.5mg to 10mg.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took account of all the oral and documentary evidence it had received in this case, together with the submissions made by Ms Bass, on behalf of the NMC, and Ms Parker, instructed by Blackfords LLP, on your behalf.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard oral evidence from the following witnesses called on behalf of the NMC who, at the time of the events, were employed in the following roles:

- Dr 1: Junior Clinical Fellow in the Department at the Trust

- Ms 2: Clinical Nurse Specialist for Sickle and Thalassemia patients at the Trust
- Ms 3: Bank nurse working her first shift in the Department at the Trust
- Ms 4: Manager of the Department during the day at the Trust
- Ms 5: Advanced Nurse Practitioner Trainee at the Trust

The panel also heard oral evidence from you.

The panel first considered the overall credibility and reliability of the witnesses in the order it had heard from them and it made the following conclusions:

The panel found Ms 3 to be a credible and honest witness who had attempted to assist the panel to the best of her knowledge and belief. It considered her evidence in-chief to have been clear and unwavering, but her answers in cross-examination to be slightly more confused. Nonetheless, the panel did not consider Ms 3 to have been attempting to mislead it or embellish her evidence in any way.

The panel found Ms 2 to be a clear, credible, and honest witness who had also attempted to assist the panel to the best of her knowledge and belief. It considered her oral evidence to have been resolute and unfaltering during questioning, and she was able to explain what she thought had occurred.

The panel found Dr 1 to be a clear and honest witness who accepted when she was unable to recollect matters due to the lapse of time. However, Dr 1 was helpful in that she was able to provide a clinical explanation for her decision-making in prescribing 7.5mg of Oxycodone and what complications could have arisen for Patient A in receiving a dose of 10mg. The panel noted that there had been some suggestion of animosity between you and Dr 1, although the panel did not get the impression that she bore any ill-will towards you during the giving of her oral evidence.

The panel found Ms 4 to be a credible, reliable and straightforward witness who had attempted to assist the panel to the best of her knowledge and belief. It noted that Ms 4 was only able to provide limited evidence to it as she had no direct involvement with the incident until she spoke with you on 25 January 2019. Her evidence consisted of an account that was largely accepted by you.

The panel also found Ms 5 to be a credible, reliable and straightforward witness. It noted that Ms 5 was asked to conduct the initial investigation into the alleged incident so she was not involved in this matter until that point. Ms 5 was able to answer the questions put to her in her oral evidence and stated that she was unaware of any animosity between you and Dr 1.

The panel found you to have been unwavering in your attempts to recollect and express your account as to the alleged events that took place on 22 January 2019. It considered your oral evidence to have been consistent with your previous accounts. You were concise in your answers, albeit, in response to a number of questions, you commented on what should have happened, instead of what actually happened on 22 January 2019. However, the panel was of the view that you were not able to explain yourself in any meaningful way in relation to the allegations against you. Overall, the panel found you to be less credible and less reliable in comparison to the NMC witnesses it had heard from.

The panel then considered each of the disputed charges and made the following findings.

Charge 1

1) Altered Patient A's prescription for Oxycodone from 7.5mg to 10mg.

This charge is found proved.

In reaching this decision, the panel took account of your evidence, along with the evidence of Dr 1, Ms 2 and Ms 3.

The panel had regard to the evidence contained within some of the NMC witness statements.

For example, it noted that Dr 1 had stated:

> *"…At some point during the shift, I was attending a patient with a booked appointment when the Registrant approached me to write an urgent prescription for a sickle cell patient who had come in to the unit and was presenting with a lot of pain. By way of explanation, Sickle Cell Disease is a health condition which affects the red blood cells and can cause the patient to experience significant pain. The Registrant further explained that she had spoken to a clinical nurse specialist named [Ms 2], and that [Ms 2] had advised to prescribe and administer 10mg of Oxycodone medication.*
>
> *I recall that the Registrant had the Patient's care plan with her and I asked to see the care plan which would detail the medication and the dosage of that medication to be prescribed to the Patient if he/she was to come in complaining of pain. On looking at the care plan, it stated that the patient was to be prescribed a maximum of 7.5mgs of Oxycodone…*

I explained to the Registrant that the care plan stated that 7.5mg of Oxycodone was to be prescribed, and that I did not feel comfortable prescribing more than what was documented on the care plan. The Registrant repeated that she had spoken to the clinical nurse specialist who advised that 10mg of Oxycodone should be prescribed. However, I was the only doctor in the unit and I did not feel comfortable prescribing 10mg, and therefore I wrote the prescription for 7.5mg of Oxycodone and gave the prescription to the Registrant…

As I was going through the drug charts, I came across the drug chart for the sickle cell patient for whom I had written a prescription earlier in the day. I noticed that the prescription which I had written had been tampered with. The entire prescription was intact; however the dosage had been changed from 7.5mg to 10.0mg. This had been done by writing a '1' in front of the seven, changing the seven to '0' and changing the '.5' to '.0'. Therefore the prescription now read "10.0mg"…"

Ms 2 had stated:

"…I was on shift on 22 January 2019. The Registrant phoned me and said that she had a sickle cell patient named Patient A who had come to the Day Unit and was in a lot of pain. The Registrant said she was about to give Patient A pain relief medication and asked me whether it would be okay for Patient A to leave the day unit to return to her dying mother after receiving the pain relief…

At no time did I speak to the Registrant about what medication Patient A was to have or how much medication Patient A was to have…".

Ms 3 had stated:

"…On 22 January 2019 there were four staff nurses working in the Haematology Day Unit. The other two nurses were busy at the time. The Registrant called for assistance for someone to second check a controlled drug ("CD") with her.

When I got to the clinical room, the Registrant was standing in front of the CD cupboard and was holding the CD book and prescription. She had already recorded the necessary information in the CD book (date, the amount of medication which had been taken and the amount of medication remaining).

I looked at the prescription prior to checking out the medication in order to check the patient name, what the medication was for and the amount to be administered. I recall that the prescription was for 10mg of Oxycodone. At this time, I did not notice that the prescription had been altered or tampered with in any way.

Following this, we took the correct amount of ampoules of the medication (10mg) and measured the amount of medication. I checked what was recorded in the CD book against the prescription, and ensured that all information in the CD book was correct. The information had been recorded correctly. The Registrant and I then signed the CD book.

After this the Registrant and I brought the medication and prescription chart to the patient. The patient was holding their name band. I asked the patient to confirm their name and date of birth and read the prescription number for the Registrant to cross check to ensure that it was correct. We confirmed the information with the patient. The Registrant administered the injection containing 10mg of Oxycodone to the patient.

After the medication was administered I signed the prescription with the Registrant…".

In determining whether Patient A's prescription had been altered, the panel had no reason to doubt Dr 1's assertion that she had prescribed 7.5mg of Oxycodone and not 10mg to Patient A on 22 January 2019. Dr 1 was able to give her clinical justification for keeping Patient A on the same dosage of Oxycodone as she had been on previously.

The panel also had sight of the actual physical version of the drug chart from 22 January 2019, and it was satisfied that this had indeed been altered from 7.5mg of Oxycodone to 10mg of Oxycodone. It was sufficiently clear to see this from the document adduced into evidence.

The panel noted that you claim the prescription read 10mg of Oxycodone when you checked it on 22 January 2019.

In determining who altered Patient A's prescription, the panel noted that there is no direct witness to this event.

You dispute key parts of the NMC witnesses' evidence. However, in considering all of the evidence before it, the panel preferred the consistent, compelling and robust evidence of the NMC witnesses to that of your evidence.

Dr 1 confirmed that she had prescribed 7.5mg of Oxycodone for Patient A. Ms 2 was adamant that she did not discuss the specifics of medication with you during this incident, and that you had only asked whether Patient A could be discharged from the Department. Ms 3 had stated that you were standing in front of the CD cupboard when she attended and confirmed that you were holding the CD book and prescription for Patient A, having already recorded the date, the amount of medication which had been taken and the amount of medication remaining in the CD book.

The panel considered you to have had the opportunity to alter Patient A's prescription, and it did not take the view that this had been done by a third party. Ms 3 was a bank staff nurse who had attended the CD cupboard in an administrative capacity only. She had not spoken to any member of staff about Patient A. Ms 3 was there solely to sign and confirm that the medication administered to Patient A matched the prescription issued.

Therefore, in taking account of all the above, the panel found charge 1 proved on the balance of probabilities, as it was more likely than not that you had altered Patient A's prescription for Oxycodone from 7.5mg to 10mg.

Charge 2

2) Your conduct in Charge 1, above, was dishonest in that you knew Dr 1 had prescribed 7.5mg of Oxycodone to Patient A but intended to create the misleading impression that 10mg had been prescribed.

This charge is found proved.

In reaching this decision, the panel account of all the evidence before it.

It had regard to the case of *Ivey v Genting Casinos Ltd t/a Crockfords [2017] UKSC 67* in determining whether you had been dishonest in your actions, as outlined in charge 1. In particular, the panel noted in paragraph 74:

> *"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."*

The panel was of the view that in altering Patient A's prescription, your actions would have lead other members of staff to believe that Patient A was to receive 10mg of Oxycodone.

You were aware that Dr 1 had only prescribed 7.5mg of Oxycodone in accordance with Patient A's care plan, having had a conversation with her about this when receiving this prescription.

Therefore, the panel was satisfied that your actions in altering the prescription were made with the intention of deceiving others into believing that Dr 1 had prescribed 10mg and not 7.5mg, as she had stated, and as shown on the actual physical version of Patient A's prescription.

You told the panel that you had not altered Patient A's prescription, and had set the prescription down when you went looking for the keys to the CD cupboard. However, the panel considered you to have fabricated a version of events that do not match what happened on that day. As per Ms 3's evidence, you had already completed a large part of the administrative side by completing parts of the CD book, prior to her arriving to conduct the second check of the administration of a controlled drug.

The panel reminded itself that it had preferred the consistent, compelling and robust evidence of the NMC witnesses to that of your evidence. The panel did not think it plausible that a third party would have randomly altered Patient A's prescription.

Therefore, the panel was of the view that when you had sought to create a misleading impression by suggesting that 10mg of Oxycodone was the recommended dose prescribed by Dr 1, when it was 7.5mg.

The panel was not satisfied that you had made an honest mistake and it determined that ordinary and decent people would consider your actions to have been dishonest.

Therefore, the panel found charge 2 proved on the balance of probabilities.

Charge 3

3) Administered 10mg of Oxycodone to Patient A when you knew that Dr 1 had prescribed 7.5mg.

This charge is found proved.

In reaching this decision, the panel took account of your evidence, along with the evidence of Ms 3.

The panel had regard to the evidence contained within Ms 3's NMC witness statement. It noted that she had stated:

> "*…The Registrant administered the injection containing 10mg of Oxycodone to the patient.*
>
> *After the medication was administered I signed the prescription with the Registrant…"*.

The panel noted that you do not appear to dispute that you administered 10mg of Oxycodone to Patient A.

The panel had found that you were aware that Patient A had been prescribed 7.5mg by Dr 1. It accepted Dr 1's evidence when she expressly told the panel that she had prescribed 7.5mg.

Therefore, the panel found charge 3 proved on the balance of probabilities.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your

fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

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

She also referred the panel to a number of other judgments including: *Cheatle v General Medical Council [2009] EWHC 645*, *Council for the Regulation of Health Care Professionals v (1) General Medical Council (2) Biswas [2006] EWHC 464 (Admin)* and *R (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin)* who stated that misconduct must be '*sufficiently serious that it can properly be described as misconduct going to fitness to practise'*.

Ms Bass invited the panel to take the view that your conduct amounted to breaches of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015)

("the Code"). She then directed the panel to specific paragraphs and identified where, in the NMC's view, your actions amounted to misconduct.

Ms Bass submitted that the misconduct in this case is threefold. Firstly, you altered the prescription for Patient A, ignoring advice from Dr 1. Secondly, you misled others in order to hide what you had done. Thirdly, you went on to administer the higher dose of medication knowing that it was contrary to advice from Dr 1.

Ms Bass submitted that your conduct undermines public confidence in the nursing profession and is at the more serious end of the fitness to practise spectrum. She submitted that your conduct placed a vulnerable patient at a risk of harm, although there is no evidence of actual harm being caused to Patient A.

Ms Bass submitted that registered nurses occupy a position of trust in society. She stated that patients and their families must be able to trust registered nurses with their lives and the lives of their loved ones. Ms Bass submitted that in order to justify that trust, registered nurses must be honest and open and act with integrity.

Ms Bass submitted that the dishonesty in this case relates to patient care, and you abused your position of trust.

Ms Bass stated that, in all the circumstances, you departed from good professional nursing practice and your actions are sufficiently serious to constitute misconduct.

Ms Parker submitted that you accept that your actions amount to misconduct.

Submissions on impairment

Ms Bass moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession

and in the NMC as a regulatory body. She referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin)*.

Ms Bass submitted that current impairment is conceptually forward thinking, so the question for the panel to consider is whether you are impaired as at today's date, according to *Zygmunt v General Medical Council [2008] EWHC 2643 (Admin)*.

Ms Bass submitted that even though no actual harm was caused to Patient A, the panel should consider the evidence of Dr 1, who explained that there was the potential for Patient A to suffer from respiratory depression as a result of you administering the higher dose of Oxycodone. Ms Bass submitted that it is also common sense that had the medication been different, then the outcome could have been catastrophic.

Ms Bass submitted that amending a prescription is liable to bring the nursing profession into disrepute. She submitted that dishonesty is a breach of a fundamental tenet of the nursing profession, and this is exacerbated when it places a patient at a risk of harm.

In respect of the future risk of harm to patients, Ms Bass referred the panel to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)*. She invited the panel to consider whether your misconduct is capable of remediation, whether it has indeed been remediated, and whether it is highly unlikely to be repeated.

Ms Bass submitted that by its very nature, dishonesty can be more difficult to remediate than clinical concerns. She reminded the panel that you have denied being dishonest throughout these proceedings and have so far been unable to explain any steps taken to ensure your actions are not repeated in future.

In light of the above, Ms Bass submitted that the risk of repetition in this case remains high.

Ms Bass invited the panel to find that your fitness to practice as a registered nurse is currently impaired. She concluded by saying that current impairment can be found either on the basis that there is a continuing risk of harm to the public, or that public confidence in the nursing profession and the NMC as regulator would be undermined if such a finding were not made. She submitted that such a finding is required in order to protect the public and to maintain public confidence in the nursing profession by upholding proper professional standards.

Ms Parker agreed that in considering current impairment, the panel should not be concerned with your past wrongdoing, and instead should look at how to manage any future risk you present.

Ms Parker submitted that for the past 24 months, you have practised as a registered nurse without concern. She referred the panel to multiple testimonials attesting positively to your character, work ethic, and good nursing practice.

Ms Parker submitted that you were upfront with your employers about the allegations against you, which is an example of present day honesty, and they decided that you were of a suitable character so they employed her.

Ms Parker adduced a bundle at impairment and took the panel through the extensive training and assessments you have undertaken in the past 24 months. She also called a witness, Ms 6, Clinical Practice Facilitator at University College London Hospital ("UCLH"), to give evidence in support of this.

Ms Parker informed the panel that you have completed chemotherapy training, where you have learnt how to deliver medication, how to ensure the medication dosage is correct, how to dispense medication, how to store medication, and how to administer medication. She submitted that you were subject to six months of training where you were assessed regularly on a ward, before being able to practise independently. Furthermore, Ms Parker submitted that you have also undertaken management and leadership training separate to

this and passed it successfully. She submitted that you manage 13 registered nurses on a ward, twice a week. Ms Parker submitted that patient safety is at the heart of your training.

Ms Parker told the panel that you had specifically requested to work on a Covid-19 Intensive Treatment Unit ("ITU") during the pandemic despite being vulnerable. She stated that you were a registered nurse who remained involved with controlled drugs during this time, administering important medication during 12 hour shifts. You also worked with junior and senior doctors without concern. Ms Parker submitted that working on a Covid-19 ward was the most clinically challenging period of your career.

Ms Parker submitted that you also began studying a master's degree in public health at UCLH. During this time, you worked alongside a doctor conducting research.

Ms Parker submitted that although this does not excuse your actions, the risk of harm to a patient from you administering an extra 2.5mg of Oxycodone is extremely low, especially given Patient A was familiar to staff at the Department and had been administered opioids previously. She submitted that it would not have been your intention to cause Patient A any harm. Ms Parker submitted that Patient A attended the Department the following day with chocolates and flowers to thank you for your care, although you were not at work at the time.

Ms Parker submitted that the effects of this single day has been '*hanging over you*' for the last two and a half years. She submitted that you have learnt a salutary lesson from these proceedings.

In conclusion, Ms Parker submitted that this is not a case where public confidence in the nursing profession can only be maintained by a finding of current impairment. She submitted that the extensive training and assessment will show that you are currently fit to practise as a registered nurse.

Ms Parker therefore invited the panel to find that your fitness to practise as a registered nurse is not currently impaired.

Decision and reasons on misconduct

The panel heard and accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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

The panel was of the view that your acts did fall significantly short of the standards expected of a registered nurse, and it considered them to have amounted to several breaches of the Code. Specifically:

> "***4 Act in the best interests of people at all times***
>
> ***8 Work co-operatively***
> *To achieve this, you must:*
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> *8.2 maintain effective communication with colleagues*
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> *8.6 share information to identify and reduce risk*
>
> ***9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues***
> *To achieve this, you must:*

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:

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

Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

20 Uphold the reputation of your profession at all times
To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, in these circumstances, the panel decided that your actions in each of the charges found proved fell significantly short of the standards expected so as to justify a finding of misconduct.

The panel considered the charges to be serious, particularly, your dishonesty. It was of the view that the dishonesty involved related directly to patient care, and that you abused your position of trust in altering Patient A's prescription of 7.5mg to 10mg of Oxycodone. It had found you to have attempted to mislead members of staff into believing that Patient A had been prescribed 10mg by Dr 1, and that you had also administered 10mg of Oxycodone to Patient A with the awareness that this was the incorrect dosage.

The panel was concerned that administering a higher dosage of a controlled drug could have had serious ramifications for Patient A, regardless of the amount. It considered the specific details of a prescription authorised by a doctor to be important, and accepted the evidence of Dr 1 as to why she prescribed the quantity she did.

The panel noted that you did not positively contest misconduct through your representative. Indeed, during your own oral evidence, you accepted that a registered nurse who had acted in the way described would have fallen below accepted standards and that their actions would amount to misconduct.

The panel was of the view that other registered nurses would consider your actions to be deplorable in the particular circumstances of this case.

The panel found that your actions in charges 1, 2 and 3 did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered all of the above limbs to be engaged in this case.

The panel agreed with the submissions of Ms Bass, that you had exposed a patient in your care to a risk of harm, had acted in a way that would have brought the nursing profession into disrepute, and had breached a fundamental tenet of the nursing profession in being dishonest. The panel had received evidence to suggest that Patient A did not suffer any actual harm as a result of you administering 10mg of Oxycodone instead of 7.5mg.

In assessing your level of insight, the panel noted that you have not provided it with a reflective piece. Nonetheless, you did give oral evidence during the facts stage of this hearing, and were asked questions by the NMC and your representative in relation to misconduct and current impairment. In considering this, the panel was satisfied that you had demonstrated sufficient insight into the concerns, including dishonesty, for it to be convinced that your misconduct was highly unlikely to be repeated. Whilst you did not admit that you had behaved in a dishonest manner, the panel was satisfied that you were able to demonstrate an understanding of the seriousness of acting dishonestly in the nursing profession, and how this could adversely impact the public's perception of registered nurses. You provided an abstract view at the time, commenting on how a registered nurse should conduct themselves, and described what steps you would take if you were faced with a similar set of circumstances in future. You were able to provide the panel with real life examples of stressful personal situations where you have continued to practise effectively as a registered nurse.

In considering whether you have remediated your nursing practice, the panel considered the factors set out in *Cohen*. It noted that dishonesty is often more difficult to remediate than clinical concerns, as it could be suggestive of a deep-seated attitudinal concern. However, it is not impossible to remediate dishonest conduct and, in having regard to the totality of the evidence presented by you throughout these proceedings, the panel did not consider there to be evidence of you having a deep-seated attitudinal issue.

In deciding this, the panel took account of the positive references provided by members of staff you have worked alongside, all of whom attest positively to your high level of professionalism, character and clinical nursing skills. It accepted Ms Parker's submission that you were open and honest with your current employer about the regulatory concerns involved in this case, they were still willing to offer you employment, and have taken the opportunity to train and assess you extensively since you joined.

It noted that your dishonesty took place in what appears to be an isolated incident, and that no other concerns have been raised in respect of your conduct and behaviour, or your clinical nursing practice. To the contrary, the panel had evidence before it to suggest that you have made significant progress in your nursing career over the past 24 months. The panel was of the view that your dishonest conduct did appear to be completely out of character.

Furthermore, you have continued to practise for the last 24 months as a registered nurse without any further concerns being raised to this panel, both in respect of your character and clinical nursing practice. More recently, you have operated in positions of seniority, managing a number of registered nurses two days a week at your current place of work.

In taking account of all the above, the panel decided that a finding of impairment is not necessary on the grounds of public protection. It decided that although your fitness to practise would have been impaired on the grounds of public protection at the time of the

incidents, given all of the above, your fitness to practise on the grounds of public protection is not currently impaired.

The panel considered these proceedings to have acted as a salutary lesson for you. It was of the view that from the evidence presented, it could not be said that there is a real risk of repetition of you repeating your misconduct and, as such, determined that the risk of repetition in this case was now low.

However, 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.

Even though the events in questions occurred on 22 January 2019, some two and a half years ago, the panel considered there to be a high public interest in the consideration of this case. It was of the view that a fully informed member of the public would be concerned by the panel's findings on facts and misconduct, with particular regard to your dishonest actions. Whilst the panel acknowledged that you have continued to develop your nursing practise to such an extent that you are now considered to be a valuable asset to any team that you join, the panel was satisfied that your misconduct would need to be marked accordingly to demonstrate that your dishonest actions would not be tolerated.

In having regard to the above, the panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was required.

Taking account of all the above, the panel was satisfied that your fitness to practise as a registered nurse is currently impaired on the grounds of public interest alone.

Decision and reasons on application for hearing to be held in private

Prior to making submissions on sanction, Ms Parker made a request for parts of the hearing be held in private on the basis that proper exploration of this case may involve reference to your health. She submitted that any public interest in these parts of the case being aired in public session is outweighed by the need to protect your privacy in this respect. This application was made pursuant to Rule 19 of the NMC (Fitness to Practise) Rules 2004, as amended ("the Rules").

Ms Bass agreed with the application.

The legal assessor reminded the panel that while Rule 19 (1) provides, as a starting point, that hearings shall be conducted in public, Rule 19 (3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Rule 19 states:

> 19.—(1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.
>
> (2) Subject to paragraph (2A), a hearing before the Fitness to Practise Committee which relates solely to an allegation concerning the registrant's physical or mental health must be conducted in private.
>
> (2A) All or part of the hearing referred to in paragraph (2) may be held in public where the Fitness to Practise Committee—
>
> (a) having given the parties, and any third party whom the Committee considers it appropriate to hear, an opportunity to make representations; and

(b) having obtained the advice of the legal assessor, is satisfied that the public interest or the interests of any third party outweigh the need to protect the privacy or confidentiality of the registrant.

(3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied—

(a) having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and

(b) having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.

(4) In this rule, "in private" means conducted in the presence of every party and any person representing a party, but otherwise excluding the public.

Having heard that there may be reference to your health, the panel determined to hold such parts of the hearing in private. The panel determined to rule on whether or not to go into private session in connection with these matters as and when such issues are raised.

Sanction

The panel has considered this case very carefully and has decided to make a caution order for a period of three years. The effect of this order is that your name on the NMC register will show that you are subject to a caution order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Ms Bass invited the panel to have regard to the aggravating factors which, in the NMC's view, were present in this case. She also invited the panel to take account of any contextual factors which may have given rise to mitigation.

Ms Bass took the panel through the sanctions available to it in turn.

Ms Bass submitted that as the panel has found there to be an outstanding public interest concern, no further action is not appropriate in the particular circumstances of this case. Ms Bass submitted that the panel should take action to secure the public's trust in registered nurses, and to promote and maintain proper professional standards and conduct.

Ms Bass submitted that a caution order is the least restrictive sanction. She referred the panel to the NMC Sanctions Guidance ("SG") which states that a caution order is only appropriate where the case is at the lower end of the spectrum of impaired fitness to practise. Given that '*covering up*' and '*falsifying records*' are described in the SG as "*serious concerns which are more difficult to put right*", Ms Bass submitted that the misconduct cannot be described as being at the lower end of the spectrum. She therefore submitted that a caution order is not appropriate.

Ms Bass also submitted that a conditions of practice order would not be a sufficient sanction to reflect the severity of your misconduct. She submitted that there are no identifiable clinical concerns involved in this case, and the nature of the misconduct, namely dishonesty, makes it difficult to formulate workable conditions. Ms Bass submitted that the dishonesty in this case is serious, in that it occurred in a clinical setting, and it had the potential to directly impact upon care delivered to Patient A.

Ms Bass submitted that the panel has the power to impose a suspension order of up to 12 months. She submitted that the concerns involved in this case relates to a single patient,

but it was not a single instance of misconduct. Ms Bass submitted that you altered Patient A's prescription, went on to mislead colleagues into thinking the prescription was correct, and then administered controlled drugs knowing that the dosage was more than had been initially prescribed. She submitted that your actions took advantage of a junior colleague, and that the sanction of suspension is insufficient in this case.

Ms Bass submitted that although this was a one-off incident, it cannot be described as spontaneous because it required you to be dishonest on a number of occasions. Firstly, by amending the prescription, but then also in hiding that amendment from the second checker, and then denying the conduct when challenged by her employer and by the NMC.

Ms Bass submitted that you have demonstrated no remorse for your conduct and the dishonesty in this case is serious. Therefore, she submitted that it would be entirely appropriate for the panel to consider imposing a striking-off order in this case. Ms Bass submitted that the dishonesty in this case raises fundamental questions about your professionalism. She concluded by saying that a striking-off order is the only sanction that would maintain confidence in the nursing profession.

Ms Parker invited the panel to impose a caution order. However, she submitted that if the panel are not in agreement with this, it should not consider any sanction beyond that of a conditions of practice order, as this would be sufficient to meet the public interest considerations in this case.

Ms Parker informed the panel that you accept the findings of the panel. She reminded it that no other concerns have been raised in respect of your professional or clinical practice.

Ms Parker submitted that there is no evidence of there being any ill-intent in you altering Patient A's prescription and in administering 10mg of Oxycodone. However, it is accepted that this is an example of poor nursing practice.

Ms Parker submitted that the extensive training you have undertaken may have assisted you in understanding things you did wrong. She submitted that you have done all you can to rectify your behaviour and this is evidence through the panel's finding that you do not present an ongoing risk to patient safety.

Ms Parker submitted that your ongoing good nursing practice is to your credit as it has not been an easy journey for you since these events. She took the panel through a number of health concerns and financial issues.

Ms Parker submitted that that your misconduct was a one-off incident which was both opportunistic and spontaneous. You did not wake up that day intending to be dishonest, nor were you motivated by personal gain.

Ms Parker submitted that a caution order allows the panel to mark your misconduct accordingly, and that your behaviour sits firmly within that category. She reminded the panel of its finding that there is no deep-seated attitudinal concern, no identifiable area of retraining and no general incompetence. Indeed, Ms Parker submitted that your current employers consider you to be a safe and effective nursing practitioner. At most, Ms Parker submitted that your actions do not warrant a sanction higher than that of a conditions of practice order.

Ms Parker submitted that more severe sanctions would be disproportionate in the particular circumstances of this case. She invited the panel to consider whether it would be in the public interest to keep a good, competent registered nurse in nursing practice, instead of removing you temporarily or permanently from the NMC Register.

Decision and reasons on sanction

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

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

As regards aggravating factors, the panel has considered the following as relevant:

- You exposed a patient in your care to a risk of harm.
- Your dishonesty occurred in a clinical setting.

As regards mitigating factors, the panel has considered the following as relevant:

- You were not motivated by personal gain.
- Your dishonesty was spontaneous.
- You have worked for the past 24 months without incident.
- There are no previous regulatory or disciplinary findings against you.

The panel noted that you have attended this hearing and engaged throughout these proceedings. It took account of Ms Parker's submissions regarding your finances, as well as your periods of ill-health since 2019.

The panel first considered whether to take no further action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be inconsistent with the panel's earlier findings at the impairment stage of these proceedings to take no further action. It determined that it would not be appropriate or proportionate to take no further action having regard to the public interest.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution order may be appropriate

where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'*

Whilst the panel noted that dishonesty concerns are always serious, the panel was of the view the dishonest conduct must also be contextualised and put into perspective. The panel agreed with Ms Parker's submission that your dishonesty was spontaneous, occurred on one shift over a short period of time, and was not made for personal gain.

The panel noted that it had found you to have demonstrated sufficient insight into the concerns found proved. You demonstrated an awareness of how a registered nurse should conduct themselves, and explained how you would act to ensure that your nursing practice does not fall below the expected standards. You had also undertaken extensive training and assessments, and provided the panel with a number of positive testimonials commenting on your character, work ethic and clinical nursing practice. This resulted in the panel determining that there are no outstanding public protection concerns. It was satisfied that there was a low risk of repetition and, if faced with a similar set of circumstances in future, you would act appropriately.

However, the panel had determined that the public interest did require your conduct to be marked to send a clear message to the nursing profession that your actions fell below the standards expected of a registered nurse. It noted that you have made good progress in terms of developing your nursing skills and furthering your nursing career. You have continued to work in a similar environment since the incidents involving Patient A in 2019, and you manage 13 registered nurses on shift, twice a week. Ms 6 confirmed that you had undertaken a significant amount of training and was able to explain in some detail what your training and assessments consisted of. You continue to receive positive feedback from colleagues for the manner in which you conduct yourself at work.

Therefore, whilst the panel considered the charges found proved to be serious, particularly your dishonest conduct, in taking account of all the above, the panel was sufficiently

satisfied that your misconduct could be appropriately addressed, with the public interest elements served, by the imposition of a caution order.

Having considered the general principles, and looking at the totality of the findings on the evidence, the panel has determined to impose a caution order for a period of **three years**. It determined that this would be the appropriate and proportionate response to the misconduct identified in this case. This outcome would mark not only the importance of maintaining public confidence in the nursing profession, but also send the public and the nursing profession a clear message about the standards required of a registered nurse. For the next three years, any prospective employer will be on notice that your fitness to practise has been found to be impaired and that your nursing practice is subject to a caution order.

The panel considered whether placing a conditions of practice order on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel was of the view that a conditions of practice order would not be an appropriate or measurable response in this case as there are no outstanding issues around patient safety. It was aware that the concerns identified solely relate to attitudinal concerns, as there are no identifiable areas of clinical nursing practice in need of re-training. Nonetheless, the panel had found that there was no deep-seated attitudinal concern present in this case, and that these proceedings had been a salutary lesson for you.

The panel considered the imposition of a suspension order, but determined that this outcome would be disproportionate in the circumstances of this case. It was satisfied by your attempts at demonstrating insight and remediation to the point that it was now of the view that it would not be in the public interest to prevent an otherwise competent registered nurse from continuing unrestricted practice and utilising skills for the benefit of patients.

The panel has decided that a caution order would adequately serve the public interest elements of this case.

At the end of this period, the note on your entry in the NMC register will be removed. However, the NMC will keep a record of the panel's finding that your fitness to practise had been found impaired. If the NMC receives a further allegation that your fitness to practice is impaired, the record of this panel's finding and decision will be made available to any practice committee that considers any further allegation.

This decision will be confirmed to you in writing.

That concludes this determination.