Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday 1 July 2021

Virtual Meeting

Name of registrant:	**Thonozani Daphney Didi**
NMC PIN:	01H1191O
Part(s) of the register:	Registered nurse sub part 1 RN1: Adult nurse level 1 - August 2001
Area of registered address:	Bradford
Type of case:	Misconduct
Panel members:	Louise Fox (Chair, Lay member) Pauline Esson (Registrant member) Tom Ayers (Lay member)
Legal Assessor:	Nigel Ingram
Panel Secretary:	Sherica Dosunmu
Facts proved:	All Charges
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that Ms Didi was not in attendance and that the Notice of Meeting had been sent to Ms Didi by secure email on 27 May 2021.

The panel considered whether notice of this meeting had been served in accordance with the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ('the Rules'). It noted that under the recent amendments made to the Rules during the Covid-19 emergency period, a Notice of Meeting may be sent to a registrant's registered address by recorded delivery and first-class post, or to a suitable email address on the register.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date, and how Ms Didi could make comments and put any information before the panel that she felt was relevant.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Ms Didi has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34.

Details of charge

That you a registered nurse:

1. On the 15th September 2018, at the Glan Yr Afon Care Home, in relation to the care of Resident A, failed to respond in a timely manner to the emergency alarm being activated. **[Proved]**

2. Thereafter you did not provide prompt and timely care to Resident A in that you:

    (1) Delayed in the obtaining of equipment for the assessment of vital signs; **[Proved]**

(2) Misplaced the BP cuff on Resident A's arm; **[Proved]**

(3) Delayed in the calling of an ambulance when Resident A's condition required hospital assessment. **[Proved]**

3. On the 15th September 2018, you failed to provide appropriate care to Resident B and appropriate assistance to Colleague F in that:

    (1) You did not respond to

        (a) Colleague F's call for assistance in the lounge where Resident B had suffered a fall; **[Proved]**

        (b) Colleague F shouting for the same reason. **[Proved]**

4. You failed to perform one or more of the following assessments in the care of Resident B:

    (1) An assessment of her environmental safety; **[Proved]**

    (2) Airway; **[Proved]**

    (3) Circulation; **[Proved]**

    (4) And conscious levels. **[Proved]**

5. You failed perform one or more of the following assessments in relation to Resident B:

    (1) A physical assessment of her breathing; **[Proved]**

    (2) Bruising; **[Proved]**

    (3) Pain; **[Proved]**

    (4) Fractures; **[Proved]**

    (5) Vital signs; **[Proved]**

    (6) Including her temperature; **[Proved]**

    (7) Heart rate; **[Proved]**

    (8) Oxygen saturation levels; **[Proved]**

    (9) Respiratory rate; **[Proved]**

    (10) Blood glucose readings; **[Proved]**

    (11) And urinary and chest infections. **[Proved]**

6. In relation to the record keeping of Resident B's fall:

    (1) You failed to complete an accident record in a timely manner; **[Proved]**

    (2) You did not create a body map. **[Proved]**

7. On or about the 14th September 2018, you dispensed 4mg Warfarin to Resident C when 2mg was indicated on the Anti-Coagulant Therapy record. **[Proved]**

And in light of the above your fitness to practise is impaired by virtue of your misconduct.

Background

The NMC received a referral on 19 September 2018 in relation to concerns raised while Ms Didi was working at the Glan Yr Afon Care Home (the Home). At the time of the concerns raised in the referral, Ms Didi was working as an agency nurse at the Home through McAuliffe Placement Services Ltd (the Agency).

The referral alleges that at approximately 01:00 on 15 September 2018 a care assistant became concerned about Resident A and rang an emergency buzzer, while Ms Didi was on night shift duty at the Home.

Resident A appeared to be unwell and unresponsive. In response to the emergency, another care assistant attended to assist the two colleagues who were already with Resident A. It is alleged that Ms Didi failed to respond, and once located delayed in obtaining the equipment for the assessment of Resident's A vital signs, misplaced the blood pressure cuff on Resident A's arm and delayed calling the ambulance when Resident A's condition required hospital assessment.

On 15 September 2018, at approximately 03:00 – 04:00, while Ms Didi was still on night shift duty, Resident B fell and was found on the floor in the lounge of the Home by a care assistant. It is alleged that the care assistant called Ms Didi for assistance as she walked past, but Ms Didi did not respond to her request for assistance with Resident B and did not carry out the observations or checks that were required following a fall.

It is alleged that in the morning on 15 September 2018, a nurse on day shift duty was informed by Resident C that they were given an incorrect dose of Warfarin by Ms Didi on 14 September 2018. When questioned about this, Ms Didi allegedly admitted that she had made the wrong administration to Resident C.

Following a meeting with Ms Didi on 16 September 2018, the Home decided that they would no longer require her services.

Decision and reasons on facts

The panel noted that Ms Didi made no formal response to the charges.

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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

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

- Ms 1: Care Assistant at the Home;
- Ms 2: Registered Nurse at the Home;
- Ms 3: Care Assistant at the Home.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1

1. On the 15th September 2018, at the Glan Yr Afon Care Home, in relation to the care of Resident A, failed to respond in a timely manner to the emergency alarm being activated.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Ms 1 and Ms 3. The panel considered that there was sufficient evidence available to determine that both care assistants, Ms 1 and Ms 3 were present at the Home at the time of the buzzer being activated for Resident A.

The panel observed that the contemporaneous written statements provided by Ms 1 and Ms 3 were consistent in indicating that Ms Didi's response to the emergency buzzer was delayed. Both witnesses stated that all staff were expected to respond to an emergency buzzer immediately, but Ms Didi who was the nurse on duty that night did not respond and one of witnesses had to go and find her. It was of the view that both witnesses would be fully aware of the expectations of a registered nurse in these circumstances, and both witnesses indicated that Ms Didi did not respond in a timely manner.

The panel noted that no evidence has been provided by Ms Didi regarding this matter, and in the absence of any further evidence, it concluded that there was reliable and credible evidence to prove this charge. Accordingly, the panel finds this charge proved.

Charge 2

> 2. Thereafter you did not provide prompt and timely care to Resident A in that you:
>
> (1) Delayed in the obtaining of equipment for the assessment of vital signs;
> (2) Misplaced the BP cuff on Resident A's arm;
> (3) Delayed in the calling of an ambulance when Resident A's condition required hospital assessment.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the witness statements of Ms 1 and Ms 3.

The panel observed that in their written statements Ms 1 and Ms 3 both indicated that Resident A appeared unwell and needed observations to be performed and possible hospital admission. It noted that the evidence included contemporaneous statements from both witnesses clearly explaining the circumstances at the time and indicating that there was a delay from Ms Didi in relation to sub charge (1). Ms 1 in her statement said that Ms Didi took at least 10 minutes to collect the equipment and it should not have taken this long as it was all kept together in the office.

The panel noted that Ms 1 and Ms 3 both indicated that Ms Didi misplaced the blood pressure cuff on Resident A's arm and that Ms 1 had to take over to fit it correctly. Both witnesses also stated that Ms Didi had to be prompted by them to call an ambulance, which caused a delay when Resident A's condition required hospital assessment. The panel was of the view that both witnesses as experienced care assistants would be aware of the expectations of a nurse in these circumstances and would be able to accurately identify if the blood pressure cuff was used correctly and reasonably identify a delay in calling an ambulance in such circumstances.

The panel concluded that there was mutually corroborative and credible evidence, and determined it more likely than not that Ms Didi failed to provide timely care.

Consequently, the panel found charge 2 to be proved.

Charge 3

> 3. On the 15th September 2018, you failed to provide appropriate care to Resident B and appropriate assistance to Colleague F in that:
>
> (1) You did not respond to
> (a) Colleague F's call for assistance in the lounge where Resident B had suffered a fall;
> (b) Colleague F shouting for the same reason.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the witness statements of Ms 3 and Ms 2.

The panel considered that Ms 3 (who is colleague F referred to in the allegation) made contemporaneous notes of the incident that were detailed and supported by her witness statement. She stated that she called to Ms Didi twice for help when Resident B had fallen and Ms Didi had not responded. The panel also noted that this is supported by Ms 2's statement and an Accountability Record made the following day.

The panel noted that no evidence contradicting the Accountability Record has been provided in relation to this matter. In the absence of any further evidence, it concluded that there was reliable and credible evidence to prove this charge. Accordingly, the panel finds the entirety of this charge proved.

Charge 4

> 4. You failed to perform one or more of the following assessments in the care of Resident B:
>
> (1) An assessment of her environmental safety;
> (2) Airway;
> (3) Circulation;
> (4) And conscious levels.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the witness statement of Ms 2 and documentary evidence. In her statement Ms 2 explained what should have taken place at the time in relation to the assessment of Resident B and indicated that this was not done by Ms Didi. The panel was of the view that Ms 2 would be fully aware of the expectations and duty of a fellow nurse in these circumstances.

The panel also had regard to the fact that the Accident Record that Ms Didi completed on 15 September 2018 did not record her completing any assessments with Resident B. Ms

Didi has not submitted any information regarding this charge. The panel was therefore satisfied that no assessments in the sub charges had been completed by Ms Didi and finds the entirety of the charge proved.

Charge 5

5. You failed perform one or more of the following assessments in relation to Resident B:

(1) A physical assessment of her breathing;
(2) Bruising;
(3) Pain;
(4) Fractures;
(5) Vital signs;
(6) Including her temperature;
(7) Heart rate;
(8) Oxygen saturation levels;
(9) Respiratory rate;
(10) Blood glucose readings;
(11) And urinary and chest infections.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the witness statement of Ms 1, Ms 2, Ms 3 and documentary evidence.

In her statement Ms 2 explained that Ms Didi should have completed the assessments 1-11 listed in charge 5 and explained that Ms Didi had not completed any of them. The panel was of the view that Ms 2 would be fully aware of the expectations and duty of a fellow nurse in these circumstances. There is no information before the panel to contradict Ms 2's statement in relation to this allegation.

The panel also had regard to the fact that the accident record completed by Ms Didi, dated 15 September 2018, did not document any assessments being made to Resident B. The

panel was therefore satisfied that no assessments in the sub charges had been completed by Ms Didi and finds the entirety of the charge proved.

Charge 6

6. In relation to the record keeping of Resident B's fall:

(1) You failed to complete an accident record in a timely manner;
(2) You did not create a body map.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the witness statement of Ms 2 and documentary evidence. Ms 2 confirms that no Accident Record was initially completed by Ms Didi and was completed several hours later after being prompted to do so.

The panel noted that there is no evidence or information provided to contradict Ms 2's recollection of events or explain why an Accident Record was not completed immediately by Ms Didi. In the absence of such explanation the panel was satisfied that this evidence is reliable and find this part of the charge proved.

In relation to sub charge (2) the panel accepted the evidence of Ms 2, that Ms Didi did not complete the Body Map and this fell to her to complete. This was supported by the documentary evidence of the Body Map for Resident B completed and signed by Ms 2. Therefore the panel also found this part of the charge proved.

Charge 7

7. On or about the 14th September 2018, you dispensed 4mg Warfarin to Resident C when 2mg was indicated on the Anti-Coagulant Therapy record.

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Ms 2.

In Ms 2's statement she indicated that Ms Didi admitted at the time she had administered the wrong dose of Warfarin. The panel however did not consider this to be a formal admission to the NMC allegation.

However, the panel finds that there is sufficient evidence to support the charge in Ms 2's account of Resident C's concerns about receiving the wrong dose.

The panel noted that there was no contradictory evidence to Ms 2's witness statement. Accordingly, the panel finds this charge proved.

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

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

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

NMC written representations on misconduct and impairment

In coming to its decision, the panel had regard to the following written submissions contained within the NMC's statement of case:

'It is claimed that misconduct is made out in this case. The following is set out to put a finding of misconduct in context. The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:

'[331B-E] 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 rule and standards ordinarily required to be followed by a [nursing] practitioner in the particular circumstances'. As may the comments of Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), respectively '[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'.
And 'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.

Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to, inter alia, the Nursing and Midwifery Council's Code of Conduct.'

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code). It accepted the advice of the legal assessor in respect of misconduct and impairment who referred the panel to *Roylance v GMC (No 2)* [2000] 1 A.C. 311 and *Calheam v GMC [2007] EWHC 2606 (Admin).*

The panel looked at each of the charges found proved which related to misconduct individually and cumulatively. The panel was of the view that Ms Didi's actions did fall

significantly short of the standards expected of a registered nurse, and that Ms Didi's actions amounted to a breach of the Code. Specifically:

'***Work cooperatively***
8.2. maintain effective communication with colleagues
8.5 work with colleagues to preserve the safety of those receiving care

Keep clear and accurate records relevant to your practice
10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event.

Recognise and work within the limits of your competence
13.1. accurately identify, observe and assess signs of normal or worsening physical and mental health in the 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 the limits of your competence.

15 Always offer help if an emergency arises in your practice setting or anywhere else

16 Act without delay if you believe that there is a risk to patient safety or public protection
16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

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

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

20 Uphold the reputation of your profession at all times

25.1 keep to and uphold the standards and values set out in the Code'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms Didi's failures were serious, wide ranging and involved basic nursing skills required by a registered nurse.

Taking all the information into account, the panel concluded that Ms Didi's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

NMC written representations on impairment

The panel had regard to the following written submissions contained within the NMC's statement of case:

'It is contended that impairment is made out. It needs to be considered as at today's date, i.e. whether the Registrant's fitness to practise is currently impaired. The questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions as are relevant in this case are:

(a) has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or

(b) has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or

(c)-has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future; and/or

d)-has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.
It is contended that (a), (b) and (c) apply in this case.

Unwarranted risk of harm to patients

It is expressly and/or implicitly within the charges that:

(1) The Registrant has failed to address the care of her patients with appropriate attention, skill or application.

(2) If anything, the Registrant's lack of application and focus has appeared to cause her to fail to respond, to dither and to delay in the provision of care.

(3) On one occasion, the incident in which she failed to respond to Colleague F's call for help in the care of Resident B, her attitude was closer to conscious neglect than a failure to address her obligations.

Bringing the profession into disrepute.

The Registrant's misconduct in terms of its clinical failings has also brought the profession into disrepute. The incidents in this case are serious. The public has the right to expect high standards of registered professionals.

The seriousness of the misconduct is such that it calls into question the safety of any patient under the Registrant's care. This therefore has a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute. There is a need to take action to maintain the confidence of the public in the profession and to also maintain standards.

Fundamental tenets of the profession

The provisions of the Code invoke fundamental tenets of the profession. The Registrant's actions have clearly breached a number of these as set out above.

The fact that the Registrant's acts and omissions concerned elderly vulnerable residents in a care home makes the concerns even more serious.

With regard to future risk it may assist to consider the comments of Silber J in Cohen v General Medical Council [2008] EWHC 581 (Admin) namely, whether the concerns are easily remediable, whether they have in fact been remedied and whether they are highly unlikely to be repeated. Clinical concerns are likely to be easy to remediate. The NMC guidance entitled: Is the concern remediable? (Reference: FTP-13a) is likely to be of assistance:

"Decision makers should always consider the full circumstances of the case in the round when assessing whether or not the concerns in the case can be remedied. This is true even where the incident itself is the sort of conduct which would normally be considered to be particularly serious.

The first question is whether the concerns can be remedied. That is, are there steps that the nurse or midwife can take to remedy the identified problem in their practice?
It can often be very difficult, if not impossible, to put right the outcome of the clinical failing or behaviour, especially where it has resulted in harm to a patient. However, rather than focusing on whether the outcome can be put right, decision makers should assess the conduct that led to the outcome, and consider whether the conduct itself, and the risks it could pose, can be remedied.

Decision makers need to be aware of our role in maintaining confidence in the professions by declaring and upholding proper standards of professional conduct. Sometimes, the conduct of a particular nurse or midwife can fall so far short of the standards the public expect of professionals caring for them that public confidence in the nursing and midwifery professions could be undermined.

In cases like this, and in cases where the behaviour suggests underlying problems with the nurse or midwife's attitude, it is less likely the nurse or midwife will be able to remedy their conduct. Examples of conduct which may not be possible to remedy, and where steps such as training courses or supervision at work are unlikely to address the concerns include:

• Violence, neglect or abuse of patients

Generally, issues about the safety of clinical practice are easier to remedy, particularly where they involve isolated incidents. Examples of such concerns include:

• Concerns about incidents that took place a significant period of time in the past, especially if the nurse, midwife or nursing assistant has practised safely since they occurred".

In this case, there is the clear absence of evidence of remediation and/or an engagement on the part of the Registrant to allow any real assessment of remediation.

However, the character of the original misconduct needs to be assessed:

(1) Apart from the incident concerning Resident B, this case does not appear to raise attitudinal problems in the way that the Registrant delivered care.

(2) Secondly, if anything the themes to the Registrant's misconduct appear to suggest a practitioner out of their depth (rather than one who did not care about patient care) (note the repeated references to the Registrant being somewhat vacant or unable to react).

(3) Thirdly, the events did take place [approaching] 3 years ago. This point is less forceful in the absence of knowledge as to how the Registrant has practiced since.

(4) This case did not involve actual harm to patients, although distress was caused to Resident C.

(5) The misconduct only spanned some 24 hours.

It is relevant to take account of 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 regulator and in the profession would be undermined if a finding of impairment of fitness to practice were not made in the circumstances of this case".

With regard to the public interest, it is submitted that a member of the public appraised of the facts, would not accept that a registered nurse (have made these errors) should be entitled to practice without restriction. Accordingly, taking into account all of the above, this is a matter in which a finding of impairment is required on public protection grounds and also public interests grounds.'

Decision and reasons on impairment

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

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and 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) …’*

The panel finds that patients were put at risk and could have been caused physical and emotional harm as a result of Ms Didi’s misconduct. Ms Didi’s misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Other than an early admission from Ms Didi that she had made a medication error in relation to Resident C, the panel had no evidence of Ms Didi’s current level of insight.

The panel was satisfied that the misconduct in this case is capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not Ms Didi has remedied her practice. However the panel determined that there was no evidence to indicate remediation.

The panel is of the view that due to the lack of insight or evidence of remediation there remains a real risk of repetition. Ms Didi failed to perform a number of key nursing duties as the nurse on duty on 14 -15 September 2018. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Didi's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Didi's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Ms Didi's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

NMC written representations on sanction

The panel had regard to the following written submissions contained within the NMC's statement of case:

- ***'Aggravating features***

The aggravating features of the case are as follows (non-exhaustive):

a) Lack of application to relatively fundamental nursing tasks.

b) Capacity to ignore or neglect care when the need for it presents itself clearly.
c) Inattention to important documentation in the administration of medication.
d) Lack of engagement, lack of insight and lack of remediation.

- ***Mitigating features***

The mitigating features of the case are as follows (non-exhaustive)
a) No patient harm as a result of the incidents leading to the referral (other than a degree of upset and distress in Resident C)
b) There were admissions made at the time in relation to the wrong prescription of 4 mg of warfarin to Resident C.

No order
It is suggested that such an outcome would not adequately reflect the following features:
(1) The number of clinical errors.
(2) The vulnerability of the residents.
(3) The nature of the errors, which related to core emergency care, accident response and serious medication error.

Caution
Underlying the need to protect the public and the standards of the profession lies the ongoing risk that the Registrant is not ready to practise without guidance or supervision. A caution order would not provide such a framework for ongoing monitoring of the Registrant.

Conditions of practice
It is contended that such an order would provide a proportionate sanction that would meet the needs of public protection and the protection of the profession's reputation. That such a sanction would be apt can be assessed in part from their inherent features
(1) Conditions can be fashioned to address the varying concerns in any case.

(2) They can allow the Registrant to work and to continue remediation.
(3) The conditions will be published on the NMC website.
(4) A review will follow at the end of the period to assess progress.
(5) Breaches can be actioned earlier.

NMC Guidance
The Guidance outlines features which if present, would make a conditions of practice order appropriate
(1) No evidence of attitudinal problems
(2) Identifiable areas of concern
(3) No evidence of general incompetence.
(4) Patients unlikely to be put in danger.
(5) Conditions can be reviewed and assessed.

Registrant's case
(1) No evidence or apparent attitudinal issues.
(2) 3 resident errors in narrow space of time. Concerns should be identifiable.
(3) Clinical errors that would be "remediable" with training or guidance.
(4) Whilst errors were serious, the scope of conditions to avoid future risk should not put patients in danger.

For these reasons, the NMC put forward a conditions of practice order as an appropriate sanction.

<u>Suspension</u>
NMC Guidance makes it clear that any Panel should ask itself whether the misconduct is serious enough to merit a temporary removal from the register and whether such a removal would be sufficient to protect the public. There are a number of features, highlighted in NMC Guidance, which can influence whether a suspension order is appropriate:

- *Lack of evidence of attitudinal or personality issues*
- *No evidence of repetition of the conduct since the index event.*

- *Insight on the part of the Registrant such that there is not a significant risk of repetition.*
- *Where the issue of competence is raised, continued practice is not a risk to patient safety.*

It is accepted that some or even perhaps all the above criteria for a suspension might be said to be present in this case. However, the areas of competence raised in this case appear to span only 24 hours or so. It is contended that a suspension order would not be apt as being disproportionate. The scope for any sanction is to impose the least restriction possible commensurate with the objective to protect the public and the public interest. It is claimed that a conditions of practice order will achieve this.'

Decision and reasons on sanction

Having found Ms Didi's 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 NMC Sanctions Guidance (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel accepted legal advice from the legal assessor.

The panel took into account the following aggravating features:

- Failure to complete fundamental nursing tasks.
- Capacity to ignore or neglect care when the need for it presents itself clearly.
- Inattention to important documentation in the administration of medication.
- Lack of engagement, lack of insight and lack of remediation.

The panel also took into account the following mitigating features:

- No patient harm as a result of the incidents leading to the referral (other than a degree of upset and distress in Resident C).
- There were admissions made at the time in relation to the wrong prescription of 4 mg of warfarin to Resident C.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and would not provide adequate public protection. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Didi's practice would not be appropriate in the circumstances. The SG 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.'* The panel considered that Ms Didi's 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 Ms Didi's 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;*
- *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 and protect the public.

The panel was of the view that it was in the public interest that, with appropriate safeguards, Ms Didi should be able to return to practise as a nurse and would provide her with an opportunity to remediate her practice..

Balancing all of these factors, the panel determined that 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, punitive and would not be a reasonable response in the circumstances of Ms Didi's case as the allegations found proved are remediable.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

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

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 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.

2. 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.

3. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).
   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
   e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

4. 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.

5. 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

6. You must not work as an agency nurse.

7. You must ensure that you are indirectly supervised by a band 5 or above nurse any time you are working. Your supervision must consist of:
    a) Working at all times on the same shift as but not always directly observed by a registered nurse of band 5 or above.

8. You must not administer medication unsupervised until you have completed medicines management training and have successfully passed the assessment and have been signed off as competent by your supervisor.

9. You must work with your supervisor to create a personal development plan (PDP). Your PDP must address the concerns about:

    - escalation of a deteriorating or unwell patient;
    - record keeping;
    - working in a team;
    - Responding to emergencies.

    You must:

    a) Meet with your supervisor monthly to discuss your progress towards achieving the aims set out in your PDP.
    b) Send your case officer a report from your supervisor 28 days before the next reviewing panel. This report must show your progress towards achieving the aims set out in your PDP.

The period of this order is for 12 months.

Before the end of the period of the order, a panel will hold a review hearing to see how well Ms Didi 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.

Any future panel reviewing this case may be assisted by:

- A detailed reflective piece evidencing Ms Didi's insight into the facts found proved.

This order will be confirmed to Ms Didi in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Didi's own interest until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

NMC written representations on interim order

The panel had regard to the following written submissions contained within the NMC's statement of case:

> *'An interim order of conditions is sought for 12 months for the event that a substantive order of conditions is imposed. If the substantive order is for a suspension, it is requested that an interim suspension order be made for the same period. The rationale behind such a proposal is that should the Registrant appeal, the public will be protected during the operation of the appeal period. Without the interim restriction requested, the Registrant would be able to practise unrestricted for the period up to the appeal. The time in which cases can eventually reach the appellate court may vary and can take up to 12 months.'*

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts

found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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 Ms Didi is sent the decision of this hearing in writing.

That concludes this determination.