Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
12 - 19 July 2021

Virtual Hearing

Name of registrant:	**Dawn Maria Mulherron**
NMC PIN:	81F1582E
Part(s) of the register:	Registered Nurse RN1: Adult Nurse, Level 1 (September 1984)
Area of registered address:	Tyne and Wear
Type of case:	Lack of competence
Panel members:	Wendy Yeadon (Chair, lay member) Jennifer Childs (Registrant member) Sue Rourke (Registrant member)
Legal Assessor:	Angus Macpherson
Panel Secretary:	Tyrena Agyemang
Nursing and Midwifery Council:	Represented by Jessica Bass, Case Presenter
Mrs Mulherron:	Present and represented by Tracey Lambert of UNISON
Facts proved by admission:	Charges 3a, 4a, 5a, 8a, 9a, 10a, 11a, 12a, 14a and 14b
Facts proved:	Charges 1, 2, 3b, 4b, 4c, 5b 5c, 6a, 6b, 7a, 7b, 7c, 8b, 8c, 8d, 8e, 8f, 8g, 9b, 9c, 9d, 9e, 10b, 10c, 10d, 10e, 10f, 10g, 11b, 11c, 11d, 12b, 12c, 13, 14c, 14d, 14e, 14f and 15 (in its entirety)
Facts not proved:	Charges 6c
Fitness to practise:	Impaired

Sanction:	**Conditions of practice (6 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on application to stay charge 15 for abuse of process

The panel heard an application made by Ms Lambert, on your behalf, to remove charge 15 in its entirety.

Charge 15

It was submitted by Ms Lambert that the charge is insufficiently particularised and is based on the hearsay evidence of Person 1 and should be dismissed.

The Charge reads:

> "That you, a registered nurse:
>
> 15) Before 7 April 2017:
>
> a) Did not positively identify one patient in medication round;
> b) Administered 200mg of Docusate instead of 100mg;
> c) Prepared to administer Petpac instead of paracetamol;
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

The panel heard submissions from Ms Lambert. She submitted that charge 15 lacks particularity in the way that it is written and is vague. She submitted that there is no specific date as to when this incident was alleged to have taken place neither are there any patient details and therefore the defence is at a significant disadvantage.

Ms Lambert submitted that person 1 who was present at the time of the incident has not been called as witness by the NMC and therefore her account recorded in the minutes of the meeting on 7 April 2017 cannot be challenged. She submitted that you were not present at the meeting when this information was relayed to Ms 1; the meeting minutes are unsigned by you.

Ms Lambert submitted that you went on sick leave after this incident and never returned to work and therefore you were not given the opportunity to review and sign the meeting minutes. She invited the panel to consider the threshold for such an application and that in fairness to you the application should succeed.

Ms Lambert submitted that the charge should be stayed as it would be an abuse of process and you would not receive a fair trial should the application be rejected. Ms Lambert submitted that it would be impossible for the NMC to amend the charge to provide some particularity as it is based on hearsay evidence.

Ms Bass objected to the proposed amendment. She disagreed that the charge is vague and lacked particularity. Ms Bass submitted that the charge gives the details of the incident in question and reflected the pattern of similar errors in the case. Ms Bass agreed that the information that informs this charge is hearsay evidence. She accepted that Ms 1 was not present on the drug round but was told about the details of the incident.

Ms Bass also agreed that there is no specific date in the charge, but she referred to the meeting minutes dated 7 April 2017. She told the panel that during this meeting, when you were present, the details of the incident were discussed.

Ms Bass submitted that this charge is fair and relevant and should not be removed.

The panel accepted the advice of the legal assessor.

The panel carefully considered this application, the basis of which the panel understood. However, the panel was not satisfied there would be prejudice to you and also not satisfied that injustice would be caused to either party by rejecting the proposed amendment. It therefore determined to allow the charge to remain in its entirety. The panel determined to attach what weight it considered to be appropriate when determining whether or not this charge is found proved.

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

At the outset of the hearing, Ms Lambert made a request that this case be held partially in private on the basis that proper exploration of your case involves references to your health. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Bass had no objections to 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.

Having heard that there will be references to your health, the panel determined to hold such parts of the hearing in private.

Decision and reasons on application to amend charge 14c

The panel invited submissions from the parties as to whether it should amend the wording of charges 14c.

The proposed amendment was to change 6.25mcg to 62.5mcg.

Submission from Ms Bass

The panel heard submissions from Ms Bass who submitted the suggested amendment is a typographical error. She submitted the following amendment would provide clarity and accurately reflect the oral evidence of Ms 2 and her contemporaneous drug round notes dated 1 March 2017. The amendment is as follows:

"On 1 March 2017:

c) Requested ~~6.25~~ 62.5 mcg of Digoxin from Omnicell instead of 250mcg

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

Ms Bass submitted there is no injustice caused to either party by making the amendment and apologised on behalf of the NMC for not identifying the error earlier.

Submissions from Ms Lambert

The panel heard submissions from Ms Lambert, who agreed with Ms Bass. She concurred that the error should have been identified prior to the hearing and submitted that she is content for the amendment to charge 14c.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that the amendment was in the interests of justice. It reflected the notes of the meeting on 1 March 2017 as well as the oral evidence given. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the amendment being allowed. It was therefore appropriate to allow the amendment to ensure clarity and accuracy.

Details of charge

That you, between 6 September 2016 and 7 April 2017, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 6 Nurse:

1) On 6 September 2016 incorrectly primed the line when you erected an intravenous therapy ('IVT') line; **(Found proved)**

2) On 23 September 2016 set a McKinley pump at the incorrect rate; **(Found proved)**

3) On 5 October 2016:

a) Took two hours and fifteen minutes to complete a medication round for twelve patients; **(Proved by way of admission)**

b) Did not prioritise administering insulin; **(Found proved)**

4) On 7 October 2016:

a) Took two hours and twenty minutes to complete a medication round for 12 patients; **(Proved by way of admission)**

b) Administered a partial dose of Omeprazole to a patient; **(Found proved)**

c) Dispensed 100mg of sodium valproate instead of 1000mg; **(Found proved)**

5) On 14 October 2016:

a) Took one hour and fifty minutes to complete a medication round for 14 patients; **(Proved by way of admission)**

b) Dispensed 200mg of Trimethoprin instead of 100mg; **(Found proved)**

c) Dispensed 20mg of Omeprazole instead of 40mg **(Found proved)**

6) On 19 October 2016:

a) Were unable to calculate the rate for a blood transfusion correctly; **(Found proved)**

b) Were unable to calculate the rate for a STAT infusion of saline; **(Found proved)**

c) Did not monitor a saline infusion adequately; **(Not found proved)**

7) On 24 October 2016:

a) Dispensed Furosemide and Lactulose into the same pot; **(Found proved)**

b) Did not record administering 0.5mg of Lorazepam on a patient's chart; **(Found proved)**

c) Did not recognise a patient as nil by mouth; **(Found proved)**

8) On 8 December 2016:

a) took two hours and 55 minutes to complete a medication round for 12 patients; **(Proved by way of admission)**

b) Prepared 80mgs of Gliclazide instead of 40mgs; **(Found proved)**

c) Prepared 2.8mls of Oramorph instead of 2.5mls; **(Found proved)**

d) Prepared Viazem XL instead of Venlafaxine; **(Found proved)**

e) Did not plug in or connect nebuliser line to Salbutamol inhaler; **(Found proved)**

f) Could not explain your decision to administer Rifaximin at 11am; **(Found proved)**

g) Advised a patient with a blood glucose reading of 4.6mmols to delay their insulin dose; **(Found proved)**

9) On 18 January 2017:

a) Did not complete a medication round within ninety minutes; **(Proved by way of admission)**

b) Drew up 11 units of insulin instead of 10; **(Found proved)**

c) Drew up 15 units of Humalog instead of 14; **(Found proved)**

d) Required prompting to administer a patient's dose of Phosphate Sandoz; **(Found proved)**

e) Required prompting to dispose of sharps appropriately; **(Found proved)**

10) On 7 February 2017:

a) Did not complete a medication round within ninety minutes **(Proved by way of admission)**

b) Dispensed 4mgs of Perindopril instead of 2mgs **(Found proved)**

c) Wrongly identified a patient required Oramorph instead of Morphine Sulphate Tablets **(Found proved)**

d) Were unable to measure out a 30ml dose of Lactulose; **(Found proved)**

e) Prepared to dispense Omeprazole infusion instead of tablet; **(Found proved)**

f) Prepared to dispense a Nicotine inhaler instead of a Nicotine patch; **(Found proved)**

g) Went to the wrong bay to administer a patient's drug; **(Found proved)**

11) On 8 February 2017:

a) Did not complete a medication round within ninety minutes; **(Proved by way of admission)**

b) Drew up 31 units of insulin instead of 32; **(Found proved)**

c) Requested 2.5mgs of Bisoprolol from Omnicell instead of 1.25 mgs; **(Found proved)**

d) Requested intravenous Clarithromycin from Omnicell instead of tablets; **(Found proved)**

12) On 15 February 2017:

a) Did not complete a medication round for 14 patients within ninety minutes; **(Proved by way of admission)**

b) Did not check the time of administration before recording on controlled drugs book; **(Found proved)**

c) Identified a previous dose as midnight instead of 12.26; **(Found proved)**

13) On 16 February 2017:

a) Signed for controlled drugs before they were administered to one or more

patients; **(Found proved)**

14) On 1 March 2017:

a) did not complete a medication round for 15 patients within ninety minutes; **(Proved by way of admission)**

b) Requested Rivaroxaban from Omnicell instead of Apixaban; **(Proved by way of admission)**

c) Requested ~~6.25~~ 62.5 mcg of Digoxin from Omnicell instead of 250mcg; **(Found proved)**

d) Administered 1g paracetamol tablet instead of intravenous; **(Found proved)**

e) Identified that 1.25mls of Oramorph contained 5mg instead of 2.5mls **(Found proved)**

f) Ordered medication under the wrong patient's name; **(Found proved)**

15) Before 7 April 2017:

a) Did not positively identify one patient in medication round; **(Found proved)**

b) Administered 200mg of Docusate instead of 100mg; **(Found proved)**

c) Prepared to administer Petpac instead of paracetamol; **(Found proved)**

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

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Lambert, who informed the panel that you made admissions to charges 3a, 4a, 5a, 8a, 9a, 10a, 11a, 12a, 14a and 14b.

The panel therefore finds charges 3a, 4a, 5a, 8a, 9a, 10a, 11a, 12a, 14a and 14b proved, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Bass on behalf of the NMC and by Ms Lambert on your behalf.

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 live evidence from the following witnesses called on behalf of the NMC:

- Ms 1: Matron of Medical Services Unit at the time of the allegations

- Ms 2: Senior Sister/Ward Manager at the time of the allegations

The panel also heard evidence from you under affirmation.

Background

The charges arose whilst you were employed as a registered nurse at the Queen Elizabeth Hospital, part of the Gateshead Health NHS Foundation Trust (the Trust).

On 4 September 2016, you moved to Ward 11 where it is alleged you made a series of medication administration errors.

An alleged incident occurred on 6 September 2016, whereby you erected an IVT (Intravenous transfusion) for Patient A. After 30-60 minutes the alarm went off as the line was full of air after the patient had left and returned to the ward. You stated you did not reconnect the patient when they returned, and you were advised not to erect IVT independently until you had received training and supervision.

On 23 September 2016, it is alleged you were involved in another incident regarding Intravenous therapy. Again, you were advised only to carry out such procedures with supervision until you were judged competent.

On 25 November 2016, Ms 1 the Matron of Medical Services Unit, met with you to discuss these events and the number of alleged drug errors you were making. [PRIVATE].

Ms 1 then observed you on a drug round on 8 December 2016 and she discussed this with you after the round had been completed. It is alleged, you started at 08:10

and finished at 11:05 with only six patients having had their medications administered by you in that time. The alleged errors on this round included:

- Gliclazide - 80mgs administered instead of 40mgs.
- Oromorph - 2.8 mls administered instead of 2.5mls.
- Venlafaxine - not available, but you mistook Viazem XL for Venlafaxine
- Salbutamol - nebuliser administered but machine not plugged in and nebuliser line not connected to the machine
- Omeprazole - 20mg administered instead of 40mgs.

You were expected to carry out a drug round in 60-90 minutes for 14 patients. This was the standard set and met by other staff. Ms 1 stated that you were allegedly chaotic and without structure while carrying out your duties.

You were referred to Occupational Health for a review of your fitness to work and on 6 January 2017, Occupational Health confirmed that you were fit to work and [PRIVATE].

As a result of the continual alleged problems with accurately administering medication to patients in a timely manner, you were put on a Performance Action Plan ('the Plan'). You met with Ms 1 to discuss this Plan on 17 January 2017. This meeting included discussion of your alleged lack of competence in using medical devices such as IVT and your ineffective use of JAC and Omnicell systems. These systems were used at the Hospital for the dispensing of medication. You were also given improvement targets and were also required to deal with Datix reports effectively as part of the Plan.

Ms 2, the Senior Sister on Ward 11 also supervised some of your drug rounds.

On 18 January 2017 she observed that you allegedly:

- Drew up Glargine insulin stating it was 10 units however on checking there were 11 units.
- Drew up 15 units of Humalog instead of 14 units

- Whilst completing a patient's drug dose missed off Phosphate Sandoz and needed prompting to get it
- Had to be advised to dispose of sharps correctly as you put two insulin syringes only half way into the sharps box
- Were timed out of JAC once during the drug round
- Needed constant help with Omnicell.

On 7 February 2017 she observed that you:

- Stated a patient required Oramorph and that this was in the cupboard when MST was prescribed on JAC
- Measured out a 30mls Lactulose dose in a 25 ml pot and stated 25mls was in the pot when it was filled to 17.5mls
- Clicked on Omeprazole infusion and proceeded to type in 20mg dose, when the patient required 20mg of PO Omeprazole
- Clicked on Nicotine inhalator and typed in 15mgs for a patient who required a nicotine patch of 15mgs
- Went to administer a drug to a patient in Bay 2 when it was for the patient in Bay 1
- You dispensed 2mg Perindopril but dispensed it twice, resulting in 4mgs in the medication pot. When questioned about this you didn't accept you had made an error and you had to be shown the quantity.

You were tasked with following up training in medical devices, but you continued to make errors in drug administration, both in accuracy and timeliness.

On 16 March 2017, you had a mid-stage review of your Plan. During this meeting you expressed an interest in being redeployed.

On 7 April 2017, you were invited to a final review of your Performance Action Plan.

Despite ongoing supervision with Ms 1 and Ms 2, your performance had not improved in the critical area of medication administration. Ms 1 found that you were not safe to administer medication and that this was a key requirement of your role.

You stated during the meeting that you were seeking non-clinical roles. You were devastated and said you were going on sick leave.

Whilst still on sick leave on 10 May 2017, you were reviewed again by Occupational Health and the report stated that you had had some changes in your health and were not currently fit to work pending a GP and specialist review as part of your ongoing medical condition.

On 14 June 2017, your case was heard by a panel at the Trust. You were placed on the redeployment register for a non-clinical role and removed from your role or any involvement in medications management. This was because despite training and supervision you had allegedly failed to improve and were not safe to administer medication. No harm had come to patients during any incident but this was only because you were supervised while working.

During your oral evidence to the panel, with reference to documentation included in your bundle, you informed the panel that Ms 1 had signed your revalidation form in September 2017 and you adduced this as being evidence of your competency as a nurse. Your three-year revalidation was also signed in August 2020 by the manager of your current nursing home. Ms 1 countered this in her evidence by saying that she was unsure if she could sign the form as you were subject to the fitness to practise process. She therefore sought advice from the deputy director of nursing who advised her that she could sign the form as it related to reflective written accounts, CPD, practiced hours and feedback, not specifically competency.

You did not return to work in Ward 11 after your sick leave and your request for redeployment to a non-clinical role was unsuccessful. You worked for a while in a residential rehabilitation centre but have since retired from the Trust.

From 2 February 2019, you have worked as a band 5 nurse at Lindisfarne Nursing Home.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Ms Lambert.

The panel considered the evidence of the witnesses and made the following conclusions:

Ms 1: The panel considered the evidence of Ms 1 to be credible. The panel found her to be a helpful witness who was fair to you and gave you credit when appropriate. Ms 1 was clear in her recollection of events. She was honest when she could not remember. The panel found her to be knowledgeable. The panel found Ms 1 to be a reliable witness.

Ms 2: The panel considered the evidence of Ms 2 to be credible. The panel found Ms 2 to be helpful. Ms 2 provided a detailed picture of the Hospital and the work environment there. The panel found her to be clear with her descriptions. Although she had very poor recollection of the events which were several years ago, she was assisted by her records of events that she had made at the time. The panel found her to be honest and a reliable witness.

You: The panel was of the view that you were unclear and not direct in describing your version of events. The panel noted that at times you struggled to follow the hearing and that when you presented your evidence you were a little disorganised. It appeared to the panel, you also struggled to read the shared notes on the screen. You stated when you could not remember things and tried to answer any questions put before you. However, the panel noted that at times you were defensive. It found that your answers to some of the charges were not plausible.

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

Charge 1

That you, a registered nurse on 6 September 2016 incorrectly primed the line when you erected an intravenous therapy ('IVT') line.

This charge is found proved.

In reaching this decision, the panel took into account oral evidence from you, Ms 1 and Ms 2 as well as the meeting notes dated 13 September 2016 and the reference to the Datix. The panel did not consider that you offered a plausible alternative explanation as to why there was air in the line. The panel was of the view that it was more likely than not that you failed to prime the line properly so that air was allowed to enter and trigger the alarm on the machine. The panel considered that it was unlikely that the disconnection of the line, had caused the line to fill with air. The panel therefore found this charge proved.

Charge 2

2) On 23 September 2016 set a McKinley pump at the incorrect rate.

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Ms 1 and her meeting notes dated 23 September 2016. The meeting notes reflected the fact that you had set the rate of the McKinley Pump incorrectly. The panel noted that this was the second incident involving an intravenous infusion and that this was why you were put under supervision. The panel were not provided with any patient notes in relation to this or any other incident, but accepted there would not necessarily be any references to medical errors in any patient notes about any of the alleged failures. The reason for this is that most of your errors were rectified at the time by whoever was supervising you. The panel were not persuaded by your response to the

allegations, that “I would not do this” in the face of evidence to the contrary that you did. This charge is found proved.

Charge 3b

3) On 5 October 2016:

b) Did not prioritise administering insulin.

This charge is found proved.

In reaching this decision, the panel took into account oral evidence from Ms 2 and her notes dated 5 October 2016, documented on the same day of the incident and your oral evidence. It is clear from the evidence that you dispensed or administered several other medications prior to administering insulin, despite knowing the importance of timing in relation to that particular drug. The panel were not satisfied with your defence against the allegation which stated:

“I would not fail to prioritise the administration of insulin.”

This charge was found proved.

Charge 4b

4) On 7 October 2016:

b. Administered a partial dose of Omeprazole to a patient;

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of you and Ms 2 and Ms 2’s written notes dated 7 October 2016.

The written notes of Ms 2 stated:

"Mrs Mulherron gave part dose of medication to a patient 20mg of omeprazole given, correct dose was 40mg. I explained to Mrs Mulherron part dose should not be given to patients. Mrs Mulherron stated that the medication was unavailable (only had 20mg) however located further 20mg in patients locker and explained she did not see it as it was at the back of the drawer"

You stated that the Omnicell and JAC systems would not allow you to administer an incorrect dose. The panel noted that this medication was not in Omnicell but was in fact in the patient's locker. The fact that you had not been able to find the complete dose of medication is human error, not one of technology. In addition, Ms 2 had to identify that the dose you were giving the patient was insufficient. Ms 2 then located the remainder of the dose in the patient's locker which then allowed for the total prescribed amount to be given.

This charge is proved.

Charge 4c

4) On 7 October 2016:

c. Dispensed 100mg of sodium valproate instead of 1000mg;

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Ms 2 and the written drug round notes dated 7 October 2016 which stated:

"Mrs Mulherron went to drugs cupboard to locate and came back with sodium valproate 200mg tablets and 100mg tablets. Mrs Mulherron looked at the computer and proceeded to say 100mg and dispensed 100mg sodium valproate into pot. I explained to Mrs Mulherron that the dose of the sodium valproate was in fact 1000mg and the patients required a further 900mg. Mrs Mulherron then dispensed 1000mg using the 200mg tablets."

The panel considered the very specific detail in the notes provided which were made by Ms 2 during and/or after the drugs round with you. Your bundle, including your witness statement does not give any explanation as to this particular charge, nor was it directly addressed in your oral evidence. The panel therefore found Ms 2's evidence to be more compelling. [PRIVATE].

This charge was found proved.

Charge 5b and 5c

5) On 14 October 2016:

b. Administered a partial dose of Omeprazole to a patient;
c. Dispensed 20mg of Omeprazole instead of 40mg

These charges are found proved.

In reaching this decision, the panel took into account the oral evidence of Ms 2 and the written drug round notes dated 14 October 2016. The panel noted the improvement you had made with regards to the length of time it took you to complete the drug round. Throughout your submissions you have stated that Omnicell would not allow you to give the incorrect amount of medication. However, the panel has heard evidence to the contrary from both Ms 1 and Ms 2, who stated that Omnicell opens the relevant drawer when the patient and medication are selected from a drop-down menu. Then, it is up to the nurse to remove the correct amount of medication as prescribed, to administer to the patient. Therefore, human errors can still occur.

The panel considered the drug round notes which stated:

> *"…Mrs Mulherron… accepts there is work to be done for her to improve her efficiency when administering medications and ensuring they are given safely."*

The notes demonstrate an acceptance by you that improvement is required around the administration of medication.

The drug round notes also stated*:*

[PRIVATE]

The panel was of the view that despite the possible issue of [PRIVATE] it was incumbent upon you to ensure that you were in a position to accurately and safely dispense or administer medication.

Charge 5b and 5c are found proved.

Charge 6a and 6b

6) On 19 October 2016:

a) Were unable to calculate the rate for a blood transfusion correctly;
b) Were unable to calculate the rate for a STAT infusion of saline

This charge is found proved.

In reaching this decision, the panel took into account of the oral evidence of Ms 2 and the meeting notes date 19 October 2016 which stated:

> *"Mrs Mulherron calculated 238÷90. This was incorrect Mrs Mulherron was aware that the rate she had calculated was incorrect. I ensured the correct rate of the infusion and the infusion was commenced."*

The panel considered the evidence from Ms 2 on the correct calculation for the rate for a blood transfusion and her explanation which indicated to the panel how it

should have been calculated. The panel noted your apparent acknowledgement of the error at the time of the incident. However, in your witness statement you provide a response to this allegation, citing a series of calculations in respect of "*Syringe Drivers Palliative Rate Volume*" which is irrelevant to this charge.

The panel then went on to consider charge 6b. In Ms 2's oral evidence she described the calculation of the rate for STAT infusion of saline, as *"a basic calculation, everyday task"*. Ms 2 also advised the panel that the rate should go as fast as it can. You made no separate representations concerning this charge in your witness statement or your oral evidence. Therefore, the panel accepted the evidence of Ms 2.

These charges are found proved.

Charge 6c

6) On 19 October 2016:

c) Did not monitor a saline infusion adequately

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Ms 2 who conceded that the task of monitoring a saline infusion for a patient, could have been completed by another nurse on duty. The panel was not satisfied that it was your sole responsibility to monitor the saline infusion, or that you were the only nurse on duty. Other nurses on duty could have also monitored the machine.

The panel find this charge not proved.

Charge 7

7) On 24 October 2016:

a) Dispensed Furosemide and Lactulose into the same pot;
b) Did not record administering 0.5mg of Lorazepam on a patient's chart;
c) Did not recognise a patient as nil by mouth;

This charge is found proved in its entirety.

In reaching this decision, the panel took into account of Ms 2's written notes dated 24 October 2016 and her oral evidence. The panel considered that placing a tablet together with a liquid medication was a significant error as the panel were advised that tablets were meant to be taken with water to assist swallowing. The panel notes that you do not accept you make these kinds of mistakes. It found the evidence provided by Ms 2 together with her detailed notes, more persuasive.

With regard to recording medication given to patients, you state in your witness statement that you remember signing for it. As all witnesses in this hearing had some issues with memory recall, due to the length of time since the incidents, the panel find it hard to believe you would remember this particular incident. In addition, Ms 2's written contemporaneous notes on which she relies, clearly indicate it was not recorded.

With regard to the allegation of not recognising a patient as nil by mouth, Ms 2's evidence and written notes indicate that you were not aware of this, despite being informed at the handover.

These charges are found proved.

Charge 8b, 8c, 8d, 8e, 8f and 8g

8) On 8 December 2016:

b) Prepared 80mgs of Gliclazide instead of 40mgs;
c) Prepared 2.8mls of Oramorph instead of 2.5mls;

d) Prepared Viazem XL instead of Venlafaxine

e) Did not plug in or connect nebuliser line to Salbutamol inhaler;

f) Could not explain your decision to administer Rifaximin at 11am;

g) Advised a patient with a blood glucose reading of 4.6mmols to delay their insulin dose

These charges are found proved.

In reaching this decision, the panel took account of the oral evidence from Ms 1 and her meeting notes dated 8 December 2016. Ms 1 directly witnessed the drug round as she was supervising you on this round. She submitted, that through her intervention all the errors were rectified at the time and no harm came to any patients. The panel considered the meeting notes to be a detailed and plausible account of the errors on that day. The panel noted that you were not able to recall these incidents and therefore were not able to provide any account as to what happened.

In relation to charge 8g the panel noted the oral evidence of Ms 1. She submitted that you gave the patient the incorrect advice regarding when they should administer their insulin. The blood sugars were in the normal range and you were incorrect in suggesting the insulin should be delayed.

The panel noted the following from the meeting notes:

"I spoke to the patient, advised Mrs Mulherron satisfactory and to administer insulin. Mrs Mulherron was aware that she gave incorrect information."

The panel also noted:

"Mrs Mulherron agreed with all previously highlighted drug administration errors."

These charges are found proved.

Charge 9b, 9c, 9d and 9e

9) On 18 January 2017:

b) Drew up 11 units of insulin instead of 10;

c) Drew up 15 units of Humalog instead of 14;

d) Required prompting to administer a patient's dose of Phosphate Sandoz;

e) Required prompting to dispose of sharps appropriately;

These charges are found proved.

In reaching this decision, the panel took into account the oral evidence of Ms 2 and her drug round notes dated 18 January 2017. Ms 2 submitted that you consistently drew up more medication than was required for each patient and required prompting when you missed a patient's medication. Ms 2 was questioned as to the significance of the difference in such small doses. She stated it was very important to be accurate when measuring the medication as some patients were prescribed doses as small as 4 units. [PRIVATE] The panel considered Ms 2 oral evidence to be clear and is consistent with the drug round notes. Ms 2 in her evidence said: "*giving too much insulin can reduce blood sugar, too low the patient may have a hypo (become hypoglycaemic) and be unwell."*

The panel also note the following contained within the drug round notes:

"Once I stopped the drug round I advised Mrs Mulherron we needed a discussion. Mrs Mulherron said she needed more exposure to drug rounds."

"I advised Mrs Mulherron that she needs to ensure the correct doses of medication are given."

When you were questioned, the panel did not accept your response that you did not make the errors. It considered that your response lacked detail. The panel considered the evidence of Ms 2 taken together with the notes from the drug round was more compelling.

These charges are found proved.

Charge 10b, 10c, 10d, 10e, 10f and 10g

10) On 7 February 2017:

b) Dispensed 4mgs of Perindopril instead of 2mgs

c) Wrongly identified a patient required Oramorph instead of Morphine Sulphate Tablets

d) Were unable to measure out a 30ml dose of Lactulose;

e) Prepared to dispense Omeprazole infusion instead of tablet;

f) Prepared to dispense a Nicotine inhaler instead of a Nicotine patch;

g) Went to the wrong bay to administer a patient's drug;

These charges were found proved.

In reaching this decision, the panel took into account the oral evidence of Ms 1 and Ms 2 and you. The panel also noted the drug round notes of Ms 2 dated 7 February 2017 and the meeting notes of Ms 1 dated 16 February 2017. The panel acknowledge Ms 1 did not directly witness the errors on this drug round and could not remember who supervised the drug round on that day.

Ms 1's meeting notes contained the following:

"I did emphasize to Mrs Mulherron that I remained concerned at the amount of drug incidents that were still occurring on each drug round undertaken. We discussed individual examples."

In Ms 2's drug round notes states the following:

"Mrs Mulherron [PRIVATE]"

The panel noted this again suggested you had ongoing issues with [PRIVATE].

The panel also acknowledge in relation to charge 10g, that whilst this is proved by the evidence provided, it does not constitute a drug error. The panel accept that anyone could make this simple mistake and there was no detriment to any patient, as you stated you would check the patient's identification before administering any medication.

These charges are found proved.

Charges 11b, 11c and 11d

11) On 8 February 2017:

b) Drew up 31 units of insulin instead of 32;

c) Requested 2.5mgs of Bisoprolol from Omnicell instead of 1.25 mgs;

d) Requested intravenous Clarithromycin from Omnicell instead of tablets;

These charges were found proved.

In reaching this decision, the panel took into account the oral evidence from you and Ms 2 and referred to the drug round notes dated 8 February 2017. Ms 2 outlined how a nurse interacts with the JAC and Omnicell systems for the panel. She

submitted that she was supervising this drug round with you and had to intervene to prevent errors from occurring.

As with the case under charges 5b and 5c, the Omnicell system did not eliminate the possibility of human errors.

These charges were found proved.

Charges 12b and 12c,

12) On 15 February 2017:

b) Did not check the time of administration before recording on controlled drugs book;

c) Identified a previous dose as midnight instead of 12.26;

These charges were found proved.

In reaching this decision, the panel took into account the oral evidence of Ms 2, the drug round notes dated 15 February 2017 and your oral evidence. Ms 2 explained to the panel the procedure involved when administering a controlled drug in great detail and the importance of timing when administering any controlled drugs.

The panel noted the following in Ms 2's notes:

"Mrs Mulherron wrote 08:30 without checking the time, I informed Mrs Mulherron it was 09:05 Mrs Mulherron corrected this and then went on to sign the book. I asked Mrs Mulherron why she was signing the book as that is not following policy and informed Mrs Mulherron, we must only sign the drug book when the medication has been administered. Mrs Mulherron appeared to be in her own world when checking out the CD's and was hesitant when counting the drugs and administering the controlled drugs to the patient."

Ms 2 submitted that it was very important for patient's medication to be given at the correct timings, not only for the patient's wellbeing but also for the smooth running of the ward. The panel considered record keeping is a fundamental part of nursing and if a patient's records are not accurate there is the potential for harm.

These charges are found proved.

Charges 13a

13) On 16 February 2017:

a) Signed for controlled drugs before they were administered to one or more patients.

This charge was found proved.

In reaching this decision, the panel again took into account the oral evidence of Ms 1, the meeting notes dated 16 February 2017 and your oral evidence. The panel took account of Ms 2's explanation regarding controlled drugs. She explained that two nurses are required to sign for the controlled drug on JAC after it is administered.

In Ms 1's meeting notes of the 16 February 2017, the panel noted the following:

"Had undertaken x2 controlled drugs administration today alongside ward manager. Mrs Mulherron had not followed the procedure correctly and signed for the controlled drugs before they had been issued to the patient. Mrs Mulherron accepts that she had not followed the policy she was unsure why she had done that as she stated she knew it was wrong, she said she could not explain her actions, and new she had not followed the CD policy."

In oral evidence, you were able to articulate the correct procedures for administering controlled drugs and asserted that you always follow the procedures. However, in the evidence provided by Ms 1, it is clearly and specifically documented that you did not do so in respect of this charge. The panel found your response to this charge less than plausible and therefore, this charge was found proved.

Charges 14c, 14d, 14e and 14f

14) On 1 March 2017:

c) Requested ~~6.25~~ 62.5 mcg of Digoxin from Omnicell instead of 250mcg;

d) Administered 1g paracetamol tablet instead of intravenous;

e) Identified that 1.25mls of Oramorph contained 5mg instead of 2.5mls

f) Ordered medication under the wrong patient's name;

These charges were found proved.

In reaching this decision, the panel again took into account the oral evidence of, Ms 2, the drug round notes dated 1 March 2017 and your oral evidence. The panel considered Ms 2 evidence that she had to intervene in all of the incidents in order to correct or identify the errors.

In respect of charge 14d, the evidence is that you proceeded to administer 1g paracetamol tablet when the patient was prescribed 1g intravenous paracetamol. When the JAC system then prompted you for a witness signature for the paracetamol, you realised your error.

In respect of charge 14f, Ms 2 conceded that it would have been likely that the pharmacy would have noticed and corrected the error had the order book been actually sent to them.

Again, the panel determined that the evidence provided by the witnesses and the contents of the exhibits bundle, were more persuasive than your assertions that the errors simply didn't happen.

These charges are found proved.

Charges 15a, 15b and 15c

15) Before 7 April 2017:

a) Did not positively identify one patient in medication round;

b) Administered 200mg of Docusate instead of 100mg;

c) Prepared to administer Petpac instead of paracetamol;

These charges were found proved.

In reaching this decision, the panel took into account that these charges are based on the hearsay evidence of Person 1 who informed Ms 1 of the issues.

The panel took account of the oral evidence of Ms 1 and the meeting notes dated 7 April 2017. The panel considered the weight it should attach to the evidence as Person 1 had not been called as a witness and therefore her evidence could not be challenged. The panel also acknowledged that this medication round was said to have gone well, but for the three errors that were corrected before any harm came to any patients.

The panel considered that the incidents on this drug round were discussed with you during this meeting and you did not deny or contest the allegations at the time:

> *"Person 1, Mrs Mulherron's Mentor said that the weekend had gone well with no errors but the wrong patient had been identified and the patient had had their drugs already. Mrs Mulherron did not carry out a positive patient ID which was pointed out to her. 200 mg were administered instead of 100mg docusate. Incorrect drug – petpac rather than paracetamol. Mrs Mulherron stated she looks at the systems all the time. Ms 1 outlined that consistent mistakes were in all drug rounds. Mrs Mulherron agreed to this."*

Taking this into consideration the panel was therefore satisfied that this charge was found proved in its entirety.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on lack of competence and Impairment

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Ms Bass invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ("the Code") in making its decision.

Ms Bass submitted that the facts found proved show that your competence at the time of the incidents fell below the standard expected of a band 6 registered nurse.

She submitted that the areas of concern in this case relate to lack of knowledge, skill and judgement.

Ms Bass referred to charge 10g and submitted that although the panel determined it did not constitute a drug error, the remainder of the charges except 6c were found proven. She submitted the errors are within the remit of fundamental aspects of nursing for a band 6 nurse.

Ms Bass submitted the errors took place over an 8-month period from September 2016 until April 2017 despite you receiving additional support of supervision and mentoring. She submitted that although you were new to the ward, Ms 1 said that you had possibly worked with Omnicell prior to working on Ward 11.

Ms Bass submitted that you have consistently told the panel that the medication administration errors were caused by the new computer systems and that you did not feel supported while working. However, during your oral evidence you were referred to numerous documents which recorded that you did feel supported. Nevertheless, you told the panel that you disputed these parts of the documents although you did not raise this with Ms 1 and Ms 2. Ms Bass submitted that the errors did not occur due to lack of support, as notwithstanding the additional support and supervision the errors continued.

In respect of reasonable adjustments, when questioned Ms 1 said that she was not aware of any adjustments you should have had in place. [PRIVATE]

Ms Bass submitted that the NMC case is that the errors were not caused by lack of support or by the implementation of a new computer system, but by your lack of competence.

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 identified the specific, relevant standards of the code, where your actions amounted to a lack of

competence and invited the panel to consider if there is a lack competence and if so, to find you impaired.

The standards she referred are as follows:

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

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

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

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

20 Uphold the reputation of your profession at all times

20.1 keep to and uphold the standards and values set out in the Code"

Ms Bass then moved on to the revalidation issue. In her oral evidence Ms 1 told the panel that she had sought advice as she was unsure if she could sign off your revalidation while there were concerns over your performance. She further stated that she was allowed to sign off the revalidation as she was not signing off in relation to competency but rather for practice hours and CPD.

Ms Bass referred the panel to the Shipman Report by Dame Janet Smith as set out in the case of *CHRE v NMC & Grant [2011] EWHC 927* and to the comments of Cox J in Grant at paragraph 101. She asked the panel to consider if limbs a, b and c of the test set out by Dame Janet Smith in her Fifth Shipman Report are engaged.

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) *….'*

Ms Bass submitted that your past conduct described in the oral evidence of Ms 1 and Ms 2 suggested patient safety was put at risk; no actual harm came to any patients, but there was still a significant risk. Ms Bass referred to the evidence of Ms 1 and the significance of incorrectly priming an IVT line, and the risk of not updating patient notes. In the latter instance, patients could be given additional medication leading to an overdose. The outcomes of this, would obviously depend on the type of medication involved.

Ms Bass submitted that the errors occurred over a period of several months and your lack of competence shown over that period had the potential to bring the profession into disrepute. She submitted that nursing is a caring profession and the lack of care you demonstrated during that time would undermine the profession and public confidence in the NMC if a finding of impairment was not made.

Ms Bass asked the panel to consider what has changed since the incidents and what could be repeated in the future. She submitted it is very difficult for a registrant to address the risk of repetition when they do not accept responsibility for the mistakes occurring. She referred the panel to your reflective piece which she submitted does not evidence any insight or remorse. Ms Bass submitted that the only insight you have demonstrated is in voluntarily restricting your own practice, by choosing to work in a much slower paced environment such as the care home where you are currently employed.

Ms Bass referred to the reference from the Care Home Manager at Gainford Care Homes, where you are currently employed. The reference dated 12 July 2021 states that you have had one medication error since January 2020, but they consider you to be competent in administering medication.

Ms Bass asked the panel to consider if this change in pace is sufficient to address the risks in this case, as there is no guarantee you would continue to work in that environment. She submitted that the risk of repetition remained, and a finding of impairment must be made in order to protect the public and to maintain the public confidence in the profession.

Ms Lambert reiterated Ms Bass' submission that no patients were harmed during your time in Ward 11. She submitted that the constant supervision while you practised on Ward 11 undermined your position and you felt you were constantly under scrutiny. She submitted you only felt comfortable when working with person 1. She submitted the feeling of failure was ever present.

Ms Lambert submitted you recognise you were slow in adjusting to the JAC and Omnicell systems and that you dreaded your supervised drug rounds. She told the panel that the new medication systems gave you plenty of opportunities for error and you struggled with the system, as you had only received 20 minutes of training.

Regarding the issue of revalidation, Ms Lambert submitted that Ms 1 had informed you that she was unable to revalidate your registration due to your lack of competence and you were devastated at this news. After seeking advice, Ms 1 confirmed that she could sign off your revalidation and Ms Lambert submitted that your revalidation confirmed you were a competent nurse. Ms Lambert referred the panel to the Code and the four headings:

- Prioritise people
- Practise effectively
- Preserve safety
- Promote professionalism and trust

Ms Lambert submitted that the decision by Ms 1 to sign off your revalidation and her explanation that she was instructed by her Deputy Director of Nursing to do so, was not a reasonable explanation for completing the sign off. She submitted that Ms 1 has a duty to refuse to sign off your revalidation if she was of the opinion that you lack competence. By signing off your revalidation, she submitted, Ms 1 confirmed that you were capable of safe and effective practice.

Ms Lambert asked the panel to consider why, you were not asked to complete a drug assessment, which she submitted would have set the benchmark for where your competency lies. She submitted that when questioned, Ms 1 could not remember if it had been discussed.

Ms Lambert submitted that your employers at the time of the incidents, [PRIVATE] and their failure to implement the reasonable adjustments only contributed to your undoing. She submitted that employers must assess their staff and make the necessary adaptations in order for them to practise safely. She submitted that Ms 1 was not aware of any adaptation requirements. She further submitted that your employer should have implemented any reasonable adaptations for you as it is their responsibility, as well as yours. She submitted that the failure to implement the adaptations demonstrates a lack of support.

Ms Lambert referred the panel to the following case law: *Holton v GMC (2006) EWHC 2960, Calhaem v GMC [2007] EWHC 2606 (Admin), and Cohen v General Medical Council [2008] EWHC 581 (Admin).*

Ms Lambert submitted that the length of your nursing career is nearly 40 years, and you have no previous regulatory concerns and no previous concerns with your employer.

Ms Lambert moved on to impairment and addressed the panel on the need to protect the public and quoted from your current employer's reference within your bundle, namely:

"…Mrs Mulherron exudes a professionalism that affects her patients and everyone around her. She is respected and well-liked by the nursing staff here and she has often been used as resource by other nurses for difficult cases. She is a very reliable medical professional who knows her job very well and treats each and every person with respect."

In closing Ms Lambert told the panel that adaptations are in place in your current employment and [PRIVATE]. She submitted that, since the incidents, your current employer is satisfied that you are capable of practising safely and you are not currently impaired.

The panel accepted the advice of the legal assessor.

Decision and reasons on lack of competence

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

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable average band 6 registered nurse and not by any higher or more demanding standard.

The panel considered the evidence of your failings took place over a significant amount of time. The panel considered the evidence to be a fair sample of your work with numerous examples of your errors which were not isolated, but repeated consistently, which in the in the panel's view was unsafe and demonstrated a lack of competence.

It also recognised that whilst being supervised while working can be stressful, there is no evidence before it to suggest you asked to be supervised by someone else, when you were uncomfortable with Ms 1 or Ms 2. On the contrary, there are numerous examples of you reporting that you were "happy with the support she is receiving from staff on Ward 11".

The panel also considered that there is no evidence that confirms [PRIVATE] contributed to the errors you were making whilst working. The panel noted that the breaks you were directed to take were for meetings regarding your performance and nothing else.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that your practice was below the standard that one would expect of the average registered nurse acting in your role.

In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses 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.'*

The panel accepted the legal assessor's advice that '*deficient professional performance'* which is the term used in the Medical Act 1983 in the case of a doctor applies with equal force to a case against a nurse based on '*lack of competence'* under the Nursing and Midwifery Order 2001.

The panel found that patients were put at risk of harm as a result of your lack of competence. Your lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to lack of competence serious.

Regarding insight, the panel considered that you demonstrated very limited insight. The panel noted that you had accepted some of the charges, primarily in relation to the length of time taken to carry out the drugs rounds, but in general you had a tendency to not take responsibility for your actions or errors. The panel was of the view that you have not demonstrated an understanding of the implications of your behaviour and actions or the impact on patients, your colleagues or on the reputation of the profession. Further you have not demonstrated an understanding of the risk of harm you could have posed to patients. The panel also considered that you have not demonstrated remorse rather you focused on yourself.

In its consideration of remediation, the panel first considered whether the lack of competence was remediable and then whether it had been remedied. The panel took into account the evidence of CPD within your bundle, and your positive references including one from your current employer. The panel also took into account that you have voluntarily restricted your practice by no longer working in an acute setting and have secured employment in a care home. This does not therefore demonstrate your ability to work unrestricted in any setting. [PRIVATE]. The panel concluded that you have not remedied the deficiencies in your practice.

In considering the issue of revalidation, the panel noted that the factors to be signed off by Ms 1 related to practice hours, CPD and reflective pieces, not your fitness to practice. The guidance notes state:

“Revalidation is not:

- *An assessment of your fitness to practice or*
- *A new way to raise fitness to practice concerns.*
- *An assessment against your current/former employment*

The panel noted that the onus is on the registrant to make a declaration that their health and character enables them to practice safely and effectively.

Taking all these factors into account, the panel is of the view that there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/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.

The panel determined that, in this case, a finding of impairment on public interest grounds was also required. The panel considered that the public would expect a registered nurse, especially one with nearly 40 years of experience, to be competent to carry out the role that they are employed to do and would expect the regulator to take action in cases where a nurse has been found to be impaired by a lack competence. The panel considered that proper professional standards and public confidence in the profession would be undermined if a finding of current impairment was not made at this time.

Having regard to all of the above, the panel was satisfied that your 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 six months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Ms Bass informed the panel that in the Notice of Hearing, dated 3 June 2021, the NMC had advised you that it would seek the imposition of a conditions of practice or a suspension order, if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that conditions of practice order for a period of six months is more appropriate in light of the panel's findings.

Ms Bass asked the panel to consider the sanction guidance when making its decision. She took the panel through what, in the NMC's view, the aggravating and mitigating factors were in this case. She submitted that the potential for patient harm and the lack of remediation or full insight were all aggravating factors. However, she submitted the panel may wish to consider there is evidence of good practice since January 2020 and, as previously stated, no harm came to any patients but, there was a potential risk of harm due to your actions.

Ms Bass referred the panel to the available sanctions and submitted that it is rare in a case like this, that a caution order is imposed as the charges warrant some form of action being taken.

As the panel identified a risk of repetition, Ms Bass asked the panel to consider imposing conditions of practice. She submitted that as there is no evidence of harmful deep-seated personality, the errors relate to medication administration and you are currently working as a nurse, if conditions could be formulated, they could be

monitored and assessed. Ms Bass submitted that as you are currently working as a nurse, a six-month order would allow you ample time to speak to your employer, execute a plan and provide the NMC with evidence of your plan.

Ms Bass suggested some conditions for the panel to consider, which could include limiting your practice to one employer, working with your manager to create a Personal Development Plan (PDP) which must address the concerns with your medicines administration, prioritisation and working under pressure. She also suggested completing four supervised drug rounds and sending your case officer evidence of completion and for a report to be sent to your case officer detailing these supervised drug rounds, written by your supervisor, at least two weeks before your review hearing.

Ms Bass submitted that the imposition of a suspension order and temporary removal from the register is not required. She submitted you have been working as nurse in a care home for the last two years with only one error and it would appear that patient safety is not currently at risk.

Ms Bass submitted that a conditions of practice order for a period of six months is the appropriate and proportionate sanction in this case.

The panel also bore in mind Ms Lambert's submissions that invited the panel to consider your 40-year career with no previous regulatory concerns. She submitted that at present you pose little to no risk and the risk of repetition is low. She told the panel that you have worked with the same employer for the last two years and noted your positive character reference. She also submitted that you are subject to a medication administration drug assessment every six months.

Ms Lambert highlighted in your current employment they do not use a computerised medication administration system and the care home has up to 30 residents in their care. She submitted that you have demonstrated remediation over the past two years and that you have undertaken training, CPD and have revalidated your registration twice.

Ms Lambert concurred with Ms Bass' application for a conditions of practice order for 6 months and her suggested conditions. She submitted that a conditions of practice order would be the appropriate sanction in this case and that a suspension order is for cases with severe failings and where harm has come to patients. Ms Lambert submitted that a suspension order would have a devastating effect on you and would prevent you from further demonstrating remediation.

The panel accepted the advice of the Legal Assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of insight into failings
- A pattern of incompetence over a period of time
- A lack of competence which put patients at potential risk of suffering harm.
- Limited remorse

The panel also took into account the following mitigating features:

- The admissions that you made
- Previous good character and history
- Recent good practice

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

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 your 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 your incompetence 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

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

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

The panel had regard to the fact that these incidents happened a long time ago and that, other than these incidents, you have had an unblemished career of 40 years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that 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 would be disproportionate and would not be a reasonable response in the circumstances of your case. Furthermore it would not allow you to remediate the issues identified.

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 limit your nursing practice to your current employer, Gainford Care Homes – or to a care or nursing home employment setting.

2. You must complete four supervised drug rounds and send your case officer evidence of your successful completion.

3. You must work with your line manager, mentor or supervisor to create a personal development plan (PDP). Your PDP must address the concerns about:

    a) Medicines administration, including prioritisation

    b) A reflective piece on how your actions or inactions, have or could have, impacted upon patients, your colleagues, and the profession as a whole.

4. You must:

    a) Send your case officer a copy of your PDP prior to your next review date.

    b) Meet with line manager, mentor or supervisor at least every 4 weeks to discuss your progress towards achieving the aims set out in your PDP.

    c) Send your case officer a report from your line manager, mentor or supervisor at least 2 weeks before your review hearing in respect of completion of the four supervised drug rounds and your reflective piece.

5. 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.

6. You must keep us informed about anywhere you are studying by:

    a) Telling your case officer within seven days of accepting any course of study.

    b) Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).
    c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
    d) 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

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

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

The period of this order is for six months.

Before the order expires, a panel will hold a review hearing to see how well you 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 would be assisted by:

- Evidence of CPD in respect of medication administration
- Recent references/testimonials from your employer and/or your colleagues
- Continued engagement with the NMC

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Bass. She submitted as the substantive order cannot take effect until the 28-day appeal period has passed, she made an application for an interim order in the same terms as the substantive order, to cover this period. She made no further submissions on the application, but asked the panel to consider her earlier submissions.

The panel also took into account the submissions of Ms Lambert who concurred with the submissions of Ms Bass.

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.

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

That concludes this determination.