Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

6 – 10 & 13 – 14 September 2021

Virtual Hearing

Name of registrant:	Sherryann Gracelyn Nevins
NMC PIN:	97D0461E
Part(s) of the register:	Registered Nurse (Sub Part 1) Mental Health Nursing – April 2000
Area of Registered Address:	Birmingham
Type of Case:	Misconduct
Panel Members:	Gregory Hammond (Chair, Lay member) Melanie Lumbers (Registrant member) Nicola Dale (Lay member)
Legal Assessor:	Michael Levy
Panel Secretary:	Caroline Pringle
Mrs Nevins:	Present and represented by Conell Loggenberg
Nursing and Midwifery Council:	Represented by Adam Slack, Case Presenter
Facts proved:	1(a), 1(b), 1(c), 1(d), 1(e), 2 and 3
Facts proved by admission:	1(f), 4, 5(a), 5(b), 6, 7(a), 7(b), 8, 9(a), 9(b) and 10
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim Order:	Interim suspension order (18 months)

Details of charge (as amended)

That you, a registered nurse:

1) On 2 January 2018:

    a) Administered an unknown substance to Resident A; ***[proved]***
    b) Failed to administer a prescribed dose of Quetiapine to Resident B; ***[proved]***
    c) Falsely recorded the administration of Quetiapine on Resident B's MAR chart; ***[proved]***
    d) Failed to administer a prescribed dose of Risperidone to Resident C; ***[proved]***
    e) Falsely recorded the administration of Risperidone on Resident C's MAR chart; ***[proved]***
    f) Removed a quantity of ~~Lorazepam~~ [Lormetazepam] tablets from Bramley Court Care Home without permission or clinical reason. ***[proved by way of admission]***

2) Your actions in charge 1) c) above were dishonest as you knew you had not administered the Quetiapine to Resident B. ***[proved]***

3) Your actions in charge 1) e) above were dishonest as you knew you had not administered the Risperidone to Resident C. ***[proved]***

4) Your actions in charge 1) f) above were dishonest in that you knew the ~~Lorazepam~~ [Lormetazepam] tablets did not belong to you and had not been prescribed to you. ***[proved by way of admission]***

5) On 17 ~~April~~ [March] 2017:

    a) Failed to administer a prescribed dose of Co-Amoxiclav to Resident D; ***[proved by way of admission]***

b) Falsely recorded the administration of Co-Amoxiclav on Resident D's MAR chart; ***[proved by way of admission]***

6) Your actions in charge 5) b) above were dishonest as you knew you had not administered the Co-Amoxiclav to Resident D. ***[proved by way of admission]***

7) On 19 ~~April~~ [March] 2017;

a) Failed to administer a prescribed dose of Co-Amoxiclav to Resident D; ***[proved by way of admission]***

b) Falsely recorded the administration of Co-Amoxiclav on Resident D's MAR chart; ***[proved by way of admission]***

8) Your actions in charge 7) b) above were dishonest as you knew you had not administered the Co-Amoxiclav to Resident D. ***[proved by way of admission]***

9) On 21 ~~April~~ [March] 2017;

a) Failed to administer a prescribed dose of Co-Amoxiclav to Resident D; ***[proved by way of admission]***

b) Falsely recorded the administration of Co-Amoxiclav on Resident D's MAR chart; ***[proved by way of admission]***

10) Your actions in charge 9) b) above were dishonest as you knew you had not administered the Co-Amoxiclav to Resident D. ***[proved by way of admission]***

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

Decision and reasons on application under Rule 19

At the beginning of the hearing Mr Loggenberg, on your behalf, made an application for the entire hearing to be held in private on the basis that there would be reference to your health and other personal matters. The application was made pursuant to Rule 19 of the Rules.

Mr Slack, on behalf of the NMC, did not object 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.

The panel, having read the papers, was aware that there was reference to your health and other personal matters. However, it was of the view that these personal matters would not touch upon much of the evidence of the NMC's witnesses. The panel therefore considered that it would be possible to hold the hearing in public and go into private as and when issues relating to your health and other personal matters were raised.

Decision and reasons on application to amend charges 5, 7 and 9

At the start of the hearing, the panel identified a potential inaccuracy in the dates of charges 5, 7 and 9.

As a result, Mr Slack, on behalf of the NMC, made an application to remove the word 'April' in charges 5, 7 and 9 and replace it with 'March'. He submitted that this amendment did not affect the substance of the charges and would ensure that the charges accurately reflect the evidence.

Mr Loggenberg, on your behalf, did not object to the proposed amendments.

The panel accepted the advice of the legal assessor. Rule 28 of the Rules provides that the panel can amend the charges at any stage before making its findings of fact, provided that the required amendment can be made without injustice.

The panel decided to amend charges 5, 7 and 9 to replace 'April' with 'March'. It was satisfied that this amendment could be made without injustice, as it did not affect the substance of the charges, and would ensure that the charges accurately reflected the evidence.

Decision and reasons on application to amend charges 1(f) and 4

Mr Slack, on behalf of the NMC, made a further application to amend charges 1(f) and 4. The proposed amendment was to amend the word 'lorazepam' to 'lormetazepam'. Mr Slack submitted that this amendment would not affect the substance of either charge and could therefore be made without causing any unfairness to you.

Mr Loggenberg did not object to the proposed amendments.

The panel accepted the advice of the legal assessor, who reiterated his earlier advice regarding Rule 28.

The panel decided to allow the proposed amendments to charges 1(f) and 4. It was satisfied that these amendments were in the interests of justice and would ensure that the charges properly reflected the evidence. The panel was also satisfied that no unfairness would be caused to you by the amendments as they did not go to the substance of either charge.

Decision and reasons on application of no case to answer

After the close of the NMC's case, Mr Loggenberg made an application that there was no case to answer in respect of charges 1(d), 1(e) and charge 3. This application was made under Rule 24(7) of the Rules and pursuant to *R v Galbraith* [1981] 1 WLR 1039.

Mr Loggenberg provided the panel with written submissions. In these, he submitted that the evidence produced by the NMC was insufficient to support charge 1(d). Mr Loggenberg submitted that the NMC's case relied on Ms 1 having seen CCTV footage which allegedly showed that you had not entered Resident C's room and therefore could not have administered the risperidone to Resident C. However, he submitted that the NMC has not provided this CCTV footage. He submitted that your case would be that, on your instructions, a carer had administered the risperidone to Resident C covertly.

Mr Loggenberg also referred the panel to the page within Resident C's MAR charts which showed the tally that was kept of the remaining volume of risperidone on which it was identified that risperidone was missing. Mr Loggenberg submitted that Ms 2's evidence regarding how she had identified the discrepancy was confused and could not be relied upon.

In these circumstances, Mr Loggenberg submitted that there was no case to answer in relation to charge 1(d) and, as a result, no case to answer would automatically follow in respect of charges 1(e) and 3.

Mr Slack, on behalf of the NMC, submitted that there was sufficient evidence before the panel to support a case to answer in relation to charges 1(d), 1(e) and 3. Mr Slack referred the panel to *Taylor v Chief Constable of Cheshire* [1987] ALL ER 225 and submitted that the absence of the relevant CCTV footage did not mean that there was no case to answer, as the panel had evidence from a witness who had reviewed the footage. Mr Slack further submitted that there was evidence from the local investigation, including admissions made by you, which supported these charges and the panel should therefore conclude that there remains a case to answer. He submitted that the evidence regarding the missing risperidone was a red herring and not relevant at this stage to the panel's considerations.

The panel took account of the submissions made and accepted the advice of the legal assessor.

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel had regard to *Taylor v Chief of Constable of Cheshire* and concluded that the absence of the CCTV footage described by Ms 1 did not necessarily mean that the charges were not capable of proof. The panel had regard to all of the evidence so far, including the oral evidence of the NMC's witnesses, your responses during the local investigation, Resident C's records, and the Home's drugs policies. It was of the view that this evidence, taken at its highest, could support charges 1(d), 1(e) and 3. It therefore determined that there remained a case to answer in respect of these charges.

Background

The allegations arose while you were employed as a registered nurse at Bramley Court Care Home ('the Home'). On 3 January 2018 a member of staff found it difficult to rouse Resident A, and was told that he had been given medication the previous evening. Finding this unusual, and knowing that he was not prescribed evening medication, the member of staff raised this with the Home Manager. Enquiries were made and the CCTV footage from the day before was reviewed. It is alleged that the CCTV footage showed you putting an unidentified medication from the drugs trolley into a cup and administering it to Resident A at approximately 18:00 on 2 January 2018. None of Resident A's prescribed medications were due at that time.

It is further alleged that, on the same shift, you did not administer medication to two other residents but signed the Medication Administration Record ('MAR') charts to indicate that you had. It is also alleged that on 2 January 2018 you removed strips of tablets from a box of lormetazepam from the Home and took them home with you.

These allegations form the basis of charges 1 – 4.

It is further alleged that on three occasions in March 2017 you failed to administer medication to Resident D, but falsely signed the MAR chart to indicate that you had administered the medications.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel took into account all the oral, documentary and video evidence in this case together with the submissions made by Mr Slack, on behalf of the NMC, and those made by Mr Loggenberg on your behalf.

The panel accepted the advice of the legal assessor.

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

The panel heard oral evidence from five witnesses called on behalf of the NMC:

Ms 1 was the Home Manager at Bramley Court Care Home. Ms 1 was not a direct witness to any of the allegations but conducted the local investigation and reviewed CCTV footage from the Home for 2 January 2018. Although her memory of the events surrounding the incidents was incomplete, she helped the panel with context and thoroughly covered how she had conducted the internal investigation. The panel found her to be a credible witness.

Ms 2 was a Care Associate Practitioner at the Home. She was on duty on 3 January 2018 and, on checking on Resident A, formed the view that he didn’t seem himself and made enquiries with the senior nurse on duty. Although she could not remember details

of her medication checks, the panel found her evidence regarding Resident A to be clear and credible.

Ms 3 was employed as a staff nurse at the Home. Her written witness statement mainly concerned allegations which you had admitted at the beginning of the hearing. Her evidence was therefore of limited use to the panel in determining the disputed charges but she was able to provide useful background and context to the Home's processes.

Ms 4 was also a staff nurse at the Home. Like Ms 3, her evidence did not go to any of the disputed charges but she was able to provide useful background information regarding the Home's processes.

Ms 5 works as a CCTV Reviewer at Care Protect, which provides CCTV within care homes. She is a qualified nurse but her registration has lapsed. Ms 5 was instructed by the Home to review CCTV footage from 2 January 2018 and provide a report of her findings. The panel found her to be a professional and credible witness who accepted a couple of errors in her report which did not affect the substance of her evidence. In any event, the panel had the opportunity to view relevant segments of the CCTV footage and to draw its own conclusions.

The panel also heard oral evidence from you and had regard to the bundle you provided which included a witness statement, reflective piece, medicines training and competency assessments and references. The panel considered that you provided a plausible account during your oral evidence, including the admission of some serious failings. The panel also took into account the difficult personal circumstances you described experiencing during the period of the charges. However, your account was highly inconsistent with the account you gave during the local investigation and with the contemporaneous documentary evidence which undermined its credibility and the weight that the panel could attach to your evidence.

At the start of this hearing you admitted the following charges:

1) *On 2 January 2018:*

   a) *…*
   b) *…*
   c) *…*
   d) *…*
   e) *…*
   f) *Removed a quantity of Lormetazepam tablets from Bramley Court Care Home without permission or clinical reason.*

2) *…*

3) *…*

4) *Your actions in charge 1) f) above were dishonest in that you knew the Lormetazepam tablets did not belong to you and had not been prescribed to you.*

5) *On 17 March 2017:*

   a) *Failed to administer a prescribed dose of Co-Amoxiclav to Resident D;*
   b) *Falsely recorded the administration of Co-Amoxiclav on Resident D's MAR chart;*

6) *Your actions in charge 5) b) above were dishonest as you knew you had not administered the Co-Amoxiclav to Resident D.*

7) *On 19 March 2017;*

   a) *Failed to administer a prescribed dose of Co-Amoxiclav to Resident D;*
   b) *Falsely recorded the administration of Co-Amoxiclav on Resident D's MAR chart;*

8) *Your actions in charge 7) b) above were dishonest as you knew you had not administered the Co-Amoxiclav to Resident D.*

9) *On 21 March 2017;*

   a) *Failed to administer a prescribed dose of Co-Amoxiclav to Resident D;*
   b) *Falsely recorded the administration of Co-Amoxiclav on Resident D's MAR chart;*

10) *Your actions in charge 9) b) above were dishonest as you knew you had not administered the Co-Amoxiclav to Resident D.*

These charges were therefore announced as proved by admission.

The panel then went on to consider the remaining charges and made the following findings:

Charge 1(a)

1) On 2 January 2018:
   a) Administered an unknown substance to Resident A;

This charge is found proved.

The panel was provided with two CCTV recordings. The first showed you in the medication room at the Home on 2 January 2018 between approximately 17:32 and 17:57, where you appear to be dropping at least two items into a yellow cup from the medicines trolley. The second recording is from the residents' lounge on 2 January 2018 between 17:57 and 18:02 and shows you approaching Resident A with the yellow cup, handing it to him, waiting while he swallows the contents, then taking the cup back and leaving. The panel did not see you review the MAR chart prior to administering any drugs to Resident A.

The panel was therefore satisfied that you did administer something to Resident A on 2 January 2018. The issue it therefore had to determine was whether it was a known or an unknown substance.

According to Ms 1's evidence, Resident A was not due any medication at 18:00 on 2 January 2018. The panel had Resident A's MAR chart which confirmed the same.

In your evidence to the panel, you said that the substance that you administered to Resident A was two quetiapine tablets. You stated that the purpose of quetiapine was to calm Resident A's behaviour. Resident A's MAR chart for 2 January 2018 states that he was prescribed two quetiapine tablets a day, to be given in the morning. The MAR chart has also been signed at this time (09:00) to confirm that they were given as prescribed. However, in your evidence, you stated that you recalled the prescribing psychiatrist saying that the drug should be given at a time when Resident A most needed it. You gave evidence that Resident A's behaviour would generally escalate in the evenings and you therefore believed the prescription to be wrong. You therefore decided to administer Resident A's quetiapine at teatime (18:00) and left a note in the diary for the next day's shift to contact the doctor for advice. You were unable to tell the panel when this review was done by the psychiatrist but stated that it was before Christmas and could have been November 2017. No note was made on the MAR chart to indicate administration at a different time.

The panel reviewed the CCTV footage from the medication room. It can clearly be seen that you place two, and possibly three, items in to the yellow cup on top of the drugs trolley. These items are taken by you from within the medication trolley and appear to be opened when your hands are inside the trolley. It is not possible to see what they are. There is no documentation by you on Resident A's MAR chart or elsewhere in his records to support your case that it was quetiapine that you administered to Resident A at 18:00 on 2 January 2018.

The panel was therefore satisfied, on the balance of probabilities, that on 2 January 2018 you administered an unknown substance to Resident A.

Charge 1(a) is therefore found proved.

Charge 1(b)

1) On 2 January 2018:
    b) Failed to administer a prescribed dose of Quetiapine to Resident B;

This charge is found proved.

In reaching this decision, the panel had regard to Ms 1's evidence and Resident B's records. Resident B's MAR chart showed that she was prescribed quetiapine twice a day. Ms 1 told the panel that she had reviewed CCTV footage from the Home on 2 January 2018. Resident B had spent all day in her room and, from the CCTV footage, you did not enter her room at all during the day. It would therefore not have been possible for you to have administered the quetiapine. This CCTV footage was not available to the panel but it had no reason to doubt Ms 1's assessment of it.

During your local investigation interview with Ms 1, which took place on 12 January 2018 ten days after the incident, you were asked if you had administered Resident B's quetiapine. You said you had. You were then asked by Ms 1 if you had administered it at 14:00 and 18:00. You replied that you gave her both doses at once. However, when you gave evidence to the panel at this hearing you said that you had not administered the quetiapine yourself, but had delegated this to a carer as Resident B responded better to staff that she saw frequently. This explanation was consistent with the fact that the CCTV did not show you entering Resident B's room.

In your evidence you told the panel that you asked the carer to administer Resident B's quetiapine and they then reported back to you. You admitted that, having delegated this, you did not stay to witness the carer administering the medication, as you should

have done, and took their word that this had been completed. There was no evidence available to support your case that you had asked a carer to give the medication. The MAR chart was signed with your signature; despite there being a number of codes printed on the MAR chart to record common occurrences, including 'C' for 'carers administered', you did not record the administration as such. Moreover, the panel noted that the resident's daily notes made no mention of medication being given by a carer.

The panel was therefore satisfied, on the balance of probabilities, that on 2 January 2018 you failed to administer a prescribed dose of quetiapine to Resident B.

Charge 1(b) is therefore found proved.

Charge 1(c)

1) On 2 January 2018:
    c) Falsely recorded the administration of Quetiapine on Resident B's MAR chart;

This charge is found proved.

The panel had already determined that you failed to administer quetiapine to Resident B and, on your own account, delegated this to a carer. However, on Resident B's MAR chart you have signed your initials to indicate that you administered the medication at 14:00 and 18:00. Despite there being a number of codes printed on the MAR chart to record common occurrences, including 'C' for 'carers administered', you did not record the administration as such. The MAR chart therefore gives the impression that you administered the medication personally at 14:00 and 18:00 despite the fact that CCTV shows that you did not enter Resident B's room all day and therefore could not have done so.

The panel was therefore satisfied, on the balance of probabilities, that on 2 January 2018 you falsely recorded the administration of quetiapine on Resident B's MAR chart.

Charge 1(d)

1) On 2 January 2018:
    d) Failed to administer a prescribed dose of Risperidone to Resident C;

This charge is found proved.

In reaching this decision, the panel had regard to Ms 1's evidence and Resident C's records. Resident C's MAR chart showed that she was prescribed risperidone twice a day. Ms 1 told the panel that she had reviewed CCTV footage from the Home on 2 January 2018 and this showed that Resident C had not been given the dose of risperidone that was due at 18:00.

During your local investigation interview with Ms 1, which took place on 12 January 2018, you were asked if you had administered Resident C's risperidone. You said that you hadn't administered risperidone as Resident C was sleepy. However, in your evidence to the panel at this hearing you said that you had asked a carer to administer Resident C's risperidone covertly in her drink. You admitted that, having delegated this, you did not stay to witness the carer administering the medication, as you should have done, and took their word that this had been completed. There was no evidence available to support your case that you had asked a carer to give the medication. The MAR chart was signed with your signature; despite there being a number of codes printed on the MAR chart to record common occurrences, including 'C' for 'carers administered', you did not record the administration as such. Moreover, the panel noted that the resident's daily notes made no mention of medication being given by a carer.

The panel was therefore satisfied, on the balance of probabilities, that on 2 January 2018 you failed to administer a prescribed dose of risperidone to Resident C.

Charge 1(d) is therefore found proved.

Charge 1(e)

1) On 2 January 2018:
   e) Falsely recorded the administration of Risperidone on Resident C's MAR chart;

This charge is found proved.

The panel had already determined that you failed to administer risperidone to Resident C. You told Ms 1 during the local investigation that you had not given the medication because Resident C was sleepy. You told this panel that you had instructed a carer to administer the medication covertly in Resident C's drink. The documentation on Resident C's MAR chart does not support either of these scenarios. Despite there being a number of codes printed on the MAR chart to record common occurrences, including 'C' for 'carers administered', you did not record the administration as such. You have signed the MAR chart at 18:00 with your initials to indicate that you have administered the medication.

The panel was therefore satisfied, on the balance of probabilities, that on 2 January 2018 you falsely recorded the administration of risperidone on Resident C's MAR chart.

Charge 1(e) is therefore found proved.

Charge 2

2) Your actions in charge 1) c) above were dishonest as you knew you had not administered the Quetiapine to Resident B.

This charge is found proved.

In reaching this decision the panel had regard to the test of dishonesty as per the case of *Ivey v Genting Casinos t/a Crockfords* [2017] UKSC 67 that *'When dishonesty is in question the fact finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he*

held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by these standards, dishonest.'

The panel first considered your state of mind. The panel considered that you would have known that you had not administered the quetiapine yourself to Resident B and yet you signed the MAR chart to indicate that you had. The panel was satisfied that your actions would be viewed as dishonest by the standards of reasonable and honest people.

Accordingly, charge 2 is found proved.

Charge 3

3) Your actions in charge 1) e) above were dishonest as you knew you had not administered the Risperidone to Resident C.

This charge is found proved.

In reaching this decision the panel had regard to the test of dishonesty as per the case of *Ivey,* set out above in charge 2.

The panel first considered your state of mind. The panel considered that you would have known that you had not administered the risperidone yourself to Resident C and yet you signed the MAR chart to indicate that you had. The panel was satisfied that your actions would be viewed as dishonest by the standards of reasonable and honest people.

Accordingly, charge 3 is found proved.

Submission on misconduct and impairment

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

In his submissions Mr Slack invited the panel to take the view that your actions amounted to a breach of *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)* (the Code). He then directed the panel to specific paragraphs and identified where, in the NMC's view, your actions amounted to misconduct.

Mr Slack referred the panel to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a '*word of general effect, involving some act or omission which falls short of what would be proper in the circumstances'*.

He then 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 uphold proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Mr Slack referred the panel to the cases of *CHRE v (1) NMC (2) Grant* [2011] EWHC 927 (Admin).

Mr Loggenberg, on your behalf, submitted that you recognised the risk your actions posed to the residents but reminded the panel that no actual harm was caused. He asked the panel to be mindful of the explanations which you gave for your actions and the evidence that the panel had heard about your personal circumstances at the time. Mr Loggenberg submitted that you have cooperated with these proceedings and have demonstrated insight and remediation. He referred the panel to the written reflection and evidence of training that you have provided. He submitted that the risk of repetition

was *'very low to none'* and, therefore, the panel should find that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor who referred to *Roylance*, *Cohen v GMC* [2008] EWHC 581 (Admin) and *Grant.* The panel adopted a two-stage process in its consideration, as advised. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Decision on misconduct

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of the Code. In reaching its decision the panel had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

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

1.2 make sure you deliver the fundamentals of care effectively

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

4 Act in the best interests of people at all times

4.2 make sure that you get properly informed consent and document it before carrying out any action

10 Keep clear and accurate records relevant to your practice

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

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

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard.

13 Recognise and work within the limits of your competence

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

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

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

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

20.2 act with honesty and integrity at all times…

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your actions in respect of all of the charges amounted to misconduct.

The panel considered that administering an unknown substance to Resident A (charge 1a) went beyond the scope of your role as a registered nurse, breached fundamental principles of medicine administration and could have had serious implications for Resident A's safety and wellbeing. The panel determined that your actions in this respect fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

The panel then moved on to consider your actions in relation to Residents B and C (charges 1b, 1c, 1d, 1e, 2 and 3). Again, the panel considered that your actions breached fundamental principles of medicines administration and record keeping and could have had serious implications for the safety and wellbeing of Residents B and C. The panel determined that your actions and dishonesty in relation to these charges also fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

At the facts stage you gave evidence regarding charges 1f and 4, which you had admitted. You told the panel that on 2 January 2018 you discovered that a resident who had recently been prescribed lormetazepam had passed away. You stated that you wanted to do some research on the drug but were not allowed to use your phone at work so had taken the two strips of tablets out of the box and placed them in your uniform pocket, intending to look up details of the drug on a computer later during your break. You gave evidence that the shift became very busy and you forgot that you still had the drugs in your pocket. You said that you took them home by mistake. The panel considered that your explanation raised a number of questions, including why you took all the medication but not the packaging, why you did not immediately notify the Home when you realised that you had taken them home with you and why you did not ensure that they were returned to the Home soon after the event. The panel was aware that lormetazepam is a very strong sedative. It considered that removing any medication, but particularly a drug such as lormetazepam, from the work place for any reason fell seriously short of the standards expected of registered nurses. It accepted that mistakes can happen but considered that, if this was the case, you had not provided any credible

explanation for why you did not immediately inform the Home, for instance by telephone, that you had inadvertently taken the medication and why you instead decided to wait until you were next scheduled to attend the Home to return them. The panel therefore considered that your actions and dishonesty fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

Finally the panel considered your actions in respect of Resident D (charges 5 – 10). You admitted these charges at the beginning of the hearing and gave evidence that you had pre-signed the MAR chart as you were certain that Resident D would take their medication and you were worried that you would otherwise forget to document this. However, during the course of the relevant shifts you forgot to administer the medication. You gave evidence about the difficulties which you were experiencing in your personal life at the time which impacted on your ability to focus at work. The panel considered that your actions were a serious breach of medicines administration procedures, which are specifically put in place to reduce the risk of errors such as these. It also placed Resident D at risk of harm, as they did not receive their antibiotics. The panel bore in mind the evidence it had heard regarding your personal life at that time but considered that, while this may be considered as mitigation, it did not excuse your deliberate decision to pre-sign the MAR charts on three separate occasions. It considered that your actions in respect of charges 5 – 10 fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

Decision on impairment

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

In this regard the panel considered the test approved of by Mrs Justice Cox in the case of *CHRE v (1) NMC (2) Grant* [2011] EWHC 927 (Admin) at paragraph 76:

> *'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. *had in the past acted dishonestly and/or is liable to act dishonestly in the future'.*

The panel found that all four limbs of *Grant* were engaged in this case. The panel considered that failing to administer prescribed drugs, failing to record any administration of prescribed drugs (or other substances) and administering unknown substances had the potential to place residents at unwarranted risk of harm. The panel considered that this, together with your false record-keeping and dishonesty, breached fundamental tenets of the profession and brought the profession into disrepute.

The panel then moved on to consider whether you are likely to repeat such misconduct in the future. In doing so, it bore in mind the three questions posed by Silber J in *Cohen:* (i) is the misconduct easily remediable; (ii) has the misconduct been remediated; and (iii) is it highly unlikely to be repeated?

The panel considered that failings in respect of medicine administration and record-keeping are generally remediable. However, dishonesty and concerns regarding attitude are more difficult to remediate. The panel noted that most of the charges did not arise from a lack of skill or knowledge of the correct procedure, but rather from an attitude on

your part that you knew better: for example, your evidence that the 'unknown' substance that you administered to Resident A was quetiapine which you decided to give at a different time to that prescribed, without checking this with a doctor or other colleagues first.

The panel next moved on to consider whether you have remedied your misconduct. The panel noted the evidence before it of medicines administration training and competency assessments. Your oral evidence and written reflection also demonstrated a sound knowledge of proper medicines management procedures. However, the panel was of the view that your evidence and reflective piece lacked developed insight into your dishonesty and the motivations for your misconduct, as well as the impact that your actions could have had on the residents in your care, your colleagues, and the reputation of the profession as a whole.

The panel noted that the incidents in 2017, when you failed to administer medication to Resident D, were initially handled by the Home. The panel heard evidence that, at the time, you wrote a reflection and underwent training. Despite this, you went on to repeat similar mistakes again some nine months later. The panel was concerned that you did not appear to put your learning and reflection from that occasion into practice, resulting in repetition of similar errors.

The panel therefore considered Silber J's final question: *'Is the conduct highly unlikely to be repeated?'* In these circumstances, it concluded that there was a high risk of repetition and that therefore a finding of current impairment was required to protect the public.

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

given the serious nature of the misconduct in this case, a finding of current impairment was required on public interest grounds to uphold proper professional standards and maintain public confidence in the nursing profession.

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

Determination on sanction

The panel considered this case carefully and decided to make a striking-off order.

In reaching this decision, the panel had regard to all the evidence that has been adduced in this case, together with the submissions made by Mr Slack and Mr Loggenberg.

Mr Slack submitted that, in the NMC's view, the appropriate and proportionate sanction was a striking-off order. He submitted that the repetition of similar failings from March 2017 to January 2018, your dishonesty, and potential attitudinal issues all raised fundamental concerns about your professionalism and suitability to remain on the register. He submitted that the only sanction which would protect the public and maintain public confidence was a striking-off order.

Mr Loggenberg submitted that a striking-off order would be disproportionate and punitive. He outlined the financial impact that a striking-off order would have on you. He submitted that you are committed to the nursing profession and again referred the panel to the evidence of training and competency assessments before it. Mr Loggenberg submitted that you are currently working under interim conditions of practice, which have become less restrictive over time, and there has been no repetition of any similar issues to those found proved. He therefore invited the panel to impose a *'warning'* or to take no further action.

The panel accepted the advice of the legal assessor who referred it to the NMC's Sanctions Guidance, including the guidance on *'Considering sanctions for serious cases'*, and a number of authorities regarding dishonesty including *Parkinson v GMC* [2010] EWHC 1898 (Admin). The panel bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel considered that the aggravating factors in this case were:

- You held a position of trust with responsibility for the care of vulnerable residents;
- Your actions placed multiple residents at risk of serious harm;
- Despite concerns being raised about your medicines administration practices in March 2017, and reflective work and learning being undertaken by you at that time, you went on to repeat similar mistakes in January 2018;
- You lack insight into aspects of your failings and the effects these could have had on residents, particularly your dishonesty, which centred around medicines administration.

The panel considered that the mitigating factors in this case were:

- You have undertaken some remediation of your clinical failings by completing medication training courses;
- You have positive testimonials from qualified nurse colleagues;
- At the relevant time you were experiencing health issues and difficult personal circumstances, although the panel also bore in mind that personal mitigation will often be less relevant in regulatory proceedings, where the purpose is to protect the public, than in the criminal justice system.

Before considering each of the sanctions in turn, the panel had regard to the NMC's guidance in relation to dishonesty:

‘The most serious kind of dishonesty is when a nurse, midwife or nursing associate deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone’s care.

However, because of the importance of honesty to a nurse, midwife or nursing associate’s practice, dishonesty will always be serious.

In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*
- *direct risk to patients*
- *premeditated, systematic or longstanding deception*

Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *no risk to patients*
- *incidents in private life of nurse, midwife or nursing associate’*

The panel noted that this was not a case involving any breach of the duty of candour. Your dishonesty was also not for personal financial gain. However, you were responsible for a group of vulnerable residents and your actions placed some of them at risk of serious harm. Inaccurate or false record-keeping, particularly in relation to medicines, will always have the potential to harm patients, as it could lead to under- or

over-dosing. In this case, Resident D did not receive the antibiotics that were prescribed, Resident A received medication that had not been prescribed, and the panel could not be sure that Residents B and C had received their prescribed medications. Your dishonesty occurred in the workplace, was directly related to patient care and was repeated in January 2018, despite local action having been taken following the incidents in March 2017. For these reasons, the panel concluded that your dishonesty was towards the upper end of the spectrum.

The panel first considered whether to take no action but concluded that this would be inappropriate. Taking no further action would not restrict your practice and would therefore not protect the public from the identified risk of harm. The panel also considered that taking no further action would not mark your dishonesty and would be wholly insufficient to uphold the public interest. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered a caution order. It noted that the Sanctions Guidance 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 had already decided that your dishonesty was towards the upper end of the spectrum. It was therefore of the view that a caution order would be inappropriate in view of the seriousness of the case. It would also be insufficient to protect the public, as it would not place any restriction on your practice. 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 was mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the Sanctions Guidance, in particular:

Conditions may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

- *no evidence of harmful deep-seated personality or attitudinal problems*
- *identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining*
- *no evidence of general incompetence*
- *potential and willingness to respond positively to retraining*
- *…*
- *patients will not be put in danger either directly or indirectly as a result of the conditions*
- *the conditions will protect patients during the period they are in force*
- *conditions can be created that can be monitored and assessed*

The panel was of the view that there are no practicable or workable conditions that could be formulated, given the nature of the charges in this case. While failings in relation to medicines administration can often be addressed through conditions of practice and retraining, the panel was of the view that this would not be appropriate in your case. During the local investigation and throughout this hearing you demonstrated a sound knowledge of proper medicines administration procedures. The panel was therefore concerned that the issues in this case arose not from a lack of knowledge or skill, but from a decision on your part not to follow these procedures. The panel was of the view that it would not be possible to formulate workable conditions which would address this attitudinal issue. The panel also noted that you completed medicines training and reflection following the incidents in March 2017 but this did not prevent similar repetition in January 2018. Moreover, the panel considered that conditions of practice would be insufficient to mark the seriousness of the case, given the multiple instances of dishonesty found proved.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The Sanctions Guidance indicates that a suspension order would be appropriate where:

'… the misconduct isn't fundamentally incompatible with the nurse, midwife or nursing associate continuing to be a registered professional, and our overarching objective may be satisfied by a less severe outcome than permanent removal from the register.

…

Key things to weigh up before imposing this order include:

- *whether the **seriousness of the case** require temporary removal from the register?*
- *will a period of suspension be sufficient to protect patients, public confidence in nurses, midwives or nursing associates, or professional standards?*

Use the checklist below as a guide to help decide whether it's appropriate or not. This list is not exhaustive:

- *a single instance of misconduct but where a lesser sanction is not sufficient*
- *no evidence of harmful deep-seated personality or attitudinal problems*
- *no evidence of repetition of behaviour since the incident*
- *the Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour*
- *…*
- *…'*

The panel noted that this was not a single instance of misconduct. Your actions involved four different residents over two distinct time periods, and the medication of a fifth resident. The panel has found serious dishonesty and evidence of a potential attitudinal problem. While the panel had no evidence of any repetition since January 2018, the

local action and reflection which you undertook following the March 2017 incidents did not prevent repetition of similar failings, including dishonesty, in January 2018. In your evidence and reflection to this panel, you accepted that you made mistakes in relation to the medicines administration process, and were able to describe how it should be done. However, the panel found you to lack understanding of why the processes are in place and how they protect patients. It considered that you lacked insight into the causes, severity and impact of your dishonesty.

The panel considered that your behaviour, in particular the repeated nature of your dishonest conduct, despite local action, raised fundamental concerns about your professionalism, trustworthiness and suitability to remain on the register. It therefore decided that a suspension order would not be a sufficient, appropriate or proportionate sanction.

The panel then moved on to consider a striking-off order. It took note of the following section of the Sanctions Guidance:

> *This sanction is likely to be appropriate when what the nurse, midwife or nursing associate has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:*
>
> - *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
> - *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*
> - *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Your actions were significant and repeated departures from the standards expected of a registered nurse. The panel considered that the repeated nature of your dishonesty, and

your subsequent lack of insight, are fundamentally incompatible with your remaining on the register. The panel was of the view that to allow you to continue to practise would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order.

The panel considered that this order was also necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour, honesty and integrity required of a registered nurse.

Determination on interim order

Mr Slack made an application for an 18 month interim suspension order on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

Mr Loggenberg opposed the application. He submitted that there were no new complaints against you and the panel's decision had been based on historic events. In these circumstances Mr Loggenberg submitted that it would be unfair to stop you working during the appeal period. You also outlined the financial impact that an interim order will have on you and asked that the panel not impose an interim order.

The panel accepted the advice of the legal assessor.

The panel was satisfied that, having found your fitness to practise impaired on both public protection and public interest grounds, an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. The panel concluded that not to make an interim order at this stage would be incompatible with the seriousness of its findings and its decision on sanction. The panel appreciated that this interim order will prevent you from working as a registered nurse and may therefore

cause you financial hardship. However it determined that this was outweighed by the need to protect the public.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.