Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
9 – 20 August & 6 – 10 September 2021

Virtual Hearing

Name of registrant:	Mrs Margaret Sarah Smith
NMC PIN:	14K0007E
Part(s) of the register:	Nursing, Sub part 1 RNA, Registered Nurse- Adult (6 March 2015)
Area of registered address:	Nottinghamshire
Type of case:	Misconduct/Lack of Competence
Panel members:	Suzy Ashworth (Chair, lay member) Lorna Taylor (Registrant member) Jan Bilton (Lay member)
Legal Assessor:	Graeme Henderson
Panel Secretary:	Tara Hoole
Nursing and Midwifery Council:	Represented by Claire Stevenson, Case Presenter
Ms Smith:	Not present on 9 – 10 August 2021, Present and unrepresented on 11 – 18 August, 6 – 10 September 2021
Facts proved:	**Charges 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.3, 4.4, 7, 8.3, 9, 10, 11, 12, 13.1, 13.2, 14.1, 14.2, 15, 16, 17, 19, 21, 22.3, 23, 25.1, 25.2, 27.2.1, 27.2.2, 27.2.3, 27.6.1, 27.6.2, 28.1, 28.2, 28.3, 29, 30, 31, 32, 33, 34.1, 34.2, 35, 36**

Facts not proved:	**Charges 2.2, 3.1, 3.2, 3.3, 3.4, 4.2, 5, 6, 8.1, 8.2, 8.4, 8.5, 18, 20, 22.1, 22.2, 24, 26, 27.1, 27.3, 27.4, 27.5, 37**
Lack of competence found:	**Charges 1.1, 1.3, 1.4, 4.1, 4.3, 4.4, 10, 11, 13.2, 14.1, 14.2, 15, 16, 21, 23, 25.1, 25.2, 27.2.2, 27.2.3, 27.6.1, 27.6.2, 28.1, 28.2, 28.3**
Lack of competence not found:	**Charges 1.2, 2.1, 7, 8.3, 9, 12, 13.1, 17, 19, 22.3, 27.2.1**
Misconduct found:	**Charges 29, 30, 31, 32, 33, 34.1, 34.2, 35**
No misconduct:	**Charge 36**
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing on 9 August 2021 that Mrs Smith was not in attendance and that the Notice of Hearing letter had been sent to her registered address by recorded delivery and by first class post on 8 July 2021.

Ms Stevenson, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Smith's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence. It also contained the hyperlink to the virtual hearing.

In the light of all of the information available, the panel was satisfied that Mrs Smith had been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Smith

The panel next considered whether it should proceed in the absence of Mrs Smith. It had regard to Rule 21 and heard the submissions of Ms Stevenson who invited the panel to continue in the absence of Mrs Smith.

Ms Stevenson referred the panel to the email dated 6 August 2021 from Mrs Smith requesting that the panel did not proceed in her absence today.

In the email, Mrs Smith stated that she was of the understanding that the hearing dates would be from 11 – 13 August and 18 – 20 August 2021. She explained that she was unable to attend other dates as she was working and unable to take three weeks off work to attend the hearing. She said that after conversations with the NMC Listings Officer she had understood that the hearing was to fit around her availability where possible.

Mrs Smith requested that the hearing did not proceed without her as she would be representing herself and therefore would be at a disadvantage if witness evidence was heard without her as she would be unaware of what was being said against her and unable to defend herself.

Ms Stevenson provided the panel with all of the written correspondence between Mrs Smith and the NMC regarding the hearing dates. She highlighted that Mrs Smith had been aware of these hearing dates at the case conference meeting on 17 June 2021 and had not objected to these dates. Mrs Smith had said that she would be unable to commit to the entirety of the hearing. It was explained to Mrs Smith the importance of attending as much of the hearing as possible. She was asked to provide dates that she could not attend by 21 June 2021 but did not do so.

However, the panel had sight of an email from Mrs Smith dated 22 June 2021 in which she said that her availability was still as discussed and that she would be free every Wednesday, Thursday and Friday of each week of the hearing. The NMC responded to this email on the same date asking Mrs Smith to confirm if she would not be available on all of the Mondays and Tuesdays within the scheduled hearing dates in order to review the dates and that the NMC may then consider amending the dates. Mrs Smith did not respond to this email.

Ms Stevenson submitted that the NMC had made all reasonable efforts in compliance with the Rules. She submitted that whilst fairness to the registrant was a prime consideration, fairness to the regulator and the public interest should also be taken into account. She

referred the panel to the cases of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

Ms Stevenson highlighted that there were 17 NMC witnesses in this case who were scheduled to give evidence over the next seven days. She submitted that adjourning the case today would cause inconvenience not only to the four witnesses scheduled to give evidence over the next two days but potentially to all of the witnesses.

Ms Stevenson submitted it was fair and proportionate to proceed in Mrs Smith's absence. She said that the NMC had contacted Mrs Smith to see if the dates could be adjusted and she had not responded. She submitted that Mrs Smith had been given ample time and opportunity to raise her availability issues. She submitted that the NMC would have extreme difficulties in accommodating Mrs Smith's reduced availability at this stage given the witness availability and scheduling. She highlighted that there was a clear public interest in the expeditious disposal of this case.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R v Jones*.

The panel has decided not to proceed in the absence of Mrs Smith. In reaching this decision, the panel has considered the submissions of Ms Stevenson, the correspondence from Mrs Smith, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties.

The panel noted Mrs Smith's request that the panel do not proceed in her absence. It is clear that Mrs Smith wishes to engage with these proceedings and attend the hearing. The panel noted that Mrs Smith stated that she has to work today and tomorrow (9 – 10

August 2021) and this is the reason for her non-attendance. The panel has no information about her work circumstances or how easy it would be for her to take leave. Mrs Smith had confirmed she would be available and would attend this hearing on Wednesdays, Thursdays and Fridays (11 – 13 and 18 – 20 August 2021).

The panel had regard to the correspondence between Mrs Smith and the NMC regarding the hearing dates. Whilst the panel considered that Mrs Smith had received appropriate notice of this hearing, and it appeared that the hearing had been listed on the basis that she would not be able to attend all days, it was not sure that she had understood that witnesses would be called on the days she could not attend. The panel noted that Mrs Smith had made it clear that she had questions for the witnesses. The panel was aware that Mrs Smith was not legally represented and that there appeared to have been a misunderstanding regarding the scheduling of this hearing.

In light of this the panel considered it would be unfair to proceed in Mrs Smith's absence at this point.

The panel noted that there are 17 witnesses who have been carefully timetabled to provide evidence over the next seven days and that not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services. However, the panel was satisfied that this was justified particularly as the manner of attending virtual hearings meant that the inconvenience of rescheduling the witnesses could be reduced.

The panel acknowledged that the NMC has finite resources and the need for the expeditious disposal of the case. However, it considered that fairness to Mrs Smith is the primary consideration at this stage.

In these circumstances, the panel decided not to proceed in the absence of Mrs Smith and to adjourn these proceedings until Wednesday, 11 August 2021.

The panel noted that Mrs Smith had stated she would not be available on any Monday or Tuesday of this case. The panel has made this decision only for the 9 – 10 August 2021. Any further adjournments would need to be applied for by Mrs Smith.

11 August 2021

The panel reconvened and the hearing was opened with Mrs Smith in attendance and the charges were read.

Details of charge [as amended]

That you a registered nurse

1. In or around June 2016 whilst working for Doncaster and Bassetlaw Hospital
   1.1. On becoming aware of Patient F's low urine output did not take any action. **[found proved]**
   1.2. Were unable to manage a patient who was on sliding scale insulin. **[found proved]**
   1.3. Did not seek assistance and/or accept assistance regarding your inability to manage the patient who was on sliding scale insulin. **[found proved]**
   1.4. Were unable to recognise the significance of a patient having haematemesis. **[found proved]**
2. On an unknown date whilst working for Doncaster and Bassetlaw Hospital in relation to a patient whose airways were occluding:
   2.1. did not press the emergency buzzer. **[found proved]**
   2.2. did not alert other members of staff. **[found not proved]**

Between July 2016 and February 2017 whilst on a capability plan with the Doncaster and Bassetlaw Hospital

3. On 13/14 July 2016 in relation to Patient G who was experiencing a hypoglycaemic episode:
   3.1. Administered/or allowed more than one glucagon injection to be administered to the patient. **[found not proved]**
   3.2. Did not bleep the on call anaesthetist to attempt cannulation on the patient. **[found not proved]**
   3.3. Were unable to locate where the glucagon was kept on ward A4. **[found not proved]**

3.4. Administered Dextrogel as a first option which was not correct as the patient was experiencing a severe hypoglycaemic episode. **[found not proved]**

4. On 22 July 2016 on being informed that Patient H was experiencing a hypoglycaemic episode:

   4.1. Did not provide immediate assistance. **[found proved]**

   4.2. Gave the patient Lucozade which was incorrect as the patient had a reduced level of consciousness. **[found not proved]**

   4.3. Were unaware of what the medication glucagon was for. **[found proved]**

   4.4. Incorrectly prioritised the patient's foot dressing over the patient's hypoglycaemic episode. **[found proved]**

5. On 25 July 2016 following handover from the night shift in relation to Patient I did not familiarise yourself with the IV pumps. **[found not proved]**

6. On 1 August 2016 did not provide Patient J with any TTO's upon discharge. **[found not proved]**

7. On 10 October 2016 on conducting a handover did not provide the full details of one patients care plan. **[found proved]**

8. On 11 October 2016 in relation to a patient who was unwell with chest pain

   8.1. did not conduct a full set of observations. **[found not proved]**

   8.2. did not contact the doctor on duty. **[found not proved]**

   8.3. did not inform the nurse in charge. **[found proved]**

   8.4. did not perform an ECG. **[found not proved]**

   8.5. did not ask for assistance to conduct an ECG. **[found not proved]**

9. On 4 November 2016 on preparing the blood glucose monitor to check a patient's blood sugar level selected a venous sample for collection rather than a capillary. **[found proved]**

10. On 4 November 2016 on being aware that a patient should receive a reading ten minutes after treatment is provided stated to Colleague 1 words to the effect of "in 10

minutes but I'm not going to do it then because it won't have had the chance to go up as yet." **[found proved]**

11. On 21 November 2016 did not complete 15 minute observations on a patient who had had a blood transfusion. **[found proved]**

12. On 24 November 2016 in relation to an unknown patient dispensed 20mg of omeprazole when the correct dose was 40mg. **[found proved]**

13. On 24 November 2016 in relation to an unknown patient:

    13.1. Did not recommence IV KCL. **[found proved]**

    13.2. Did not seek assistance to recommence IV KCL. **[found proved]**

14. On 24 November 2016 when drawing up flushes and water for injections:

    14.1. Did not clean the sterile water vials. **[found proved]**

    14.2. did not clean the glass water bottles. **[found proved]**

15. On 25 November 2016 did not use IVAB labelling. **[found proved]**

16. On 25 November 2016 in relation to an unknown patient dispensed 1mg of prucalopride when the correct dose was 3mg procholperazine. **[found proved]**

17. On 25 November 2016 disposed of prucalopride in a bin when the correct procedure was to send it back to the pharmacist. **[found proved]**

18. On 6 December 2016 did not include a water injection in a patients TTO. **[found not proved]**

19. On 28 December 2016 did not carry out a syringe driver check which was due at 12.30pm. **[found proved]**

20. On 13 January 2017 were unable to say what warfarin was used for. **[found not proved]**

21. On 13 January 2017 on going to administer a patient with cynacthen iv bolus did not clean the bung. **[found proved]**

22. On 13 February 2017 in relation to Patient K:

22.1. Did not assist the patient in sitting up. **[found not proved]**

22.2. left the patients lower half exposed. **[found not proved]**

22.3. when attending to the patient did not wear gloves and/or a gown. **[found proved]**

Whilst employed at Mallard Court

23. On 26 July 2018 on checking Resident C's syringe driver at 3am and/or 5am did not recognise that it had been connected to the wrong port. **[found proved]**

Whilst employed at Forest Hill

24. On 4 October 2018 did not apply a morphine patch to a patient who required one. **[found not proved]**

Whilst employed at the Chesterfield Royal Hospital.

25. On 28 December 2018:

25.1. did not initiate checking the patients wristbands. **[found proved]**

25.2. On being informed that Patient B had a deficit had to be prompted by Colleague 2 to consider this when treating the patient. **[found proved]**

26. On 10 January 2019 gave a patient rivaroxaban which was not theirs. **[found not proved]**

27. On 18 January 2019:

27.1. did not seek assistance in managing the airvo machine. **[found not proved]**

27.2. In relation to an unknown patient did not carry out the following tasks as requested to:

27.2.1. perform a full set of repeat bloods. **[found proved]**

27.2.2. carry out an urgent ECG. **[found proved]**

27.2.3. prepare the patient for an ECG. **[found proved]**

27.3. Did not request assistance with one or more of the tasks listed at charges. 27.2.1 – 27.2.3 **[found not proved]**

27.4. In relation to a patient who had bilateral leg ulcers did not dress her ulcers. **[found not proved]**

27.5. In relation to a patient who required IV fluids did not ask another member of staff who was competent to put IV fluids up to assist. **[found not proved]**

27.6. Did not carry out one or more of the following tasks and/or did not delegate them:

27.6.1. reposition patients who were allocated to you. **[found proved]**

27.6.2. carry out incontinence checks on patients that were allocated to you. **[found proved]**

Whilst employed at Blyth Country House

28. On 15 April 2019 in relation to Resident E:

28.1. did not sign the patients MAR chart at the time of administering her oromorph. **[found proved]**

28.2. administered oromorph at 21.40pm and 00.05am which was before the prescribed time frame which was 4-6 hours. **[found proved]**

28.3. ignored Colleague 3's instruction in relation to the frequency of oromorph to be administered. **[found proved]**

29. On 10 October 2016 were unprofessional during handover in that you were rolling your eyes and/or sighing. **[found proved]**

30. On or around 9 October 2018 were unprofessional during an investigation meeting. **[found proved]**

31. On 8 June 2017 were unprofessional in that you threw a tube of sando K tablets at the wall in Bay 2. **[found proved]**

32. In September 2018 were rude and/or abrupt to Resident B's sister. **[found proved]**

33. On an unspecified date between 24 October 2018 and 6 November 2018 when speaking to Colleague 4 were unprofessional in that you said words to the effect of 'Fuck this, I am giving you my notice'. **[found proved]**

34. On an unknown date whilst working for Chesterfield Royal Hospital were unprofessional in that you:

    34.1. challenged the staff nurses who were transferring a patient by saying words to the effect of "why are you transferring this patient? You have loads of empty beds." **[found proved]**

    34.2. Said the words set out in charge 34.1 in front of the patient. **[found proved]**

35. On 16 April 2019 were unprofessional in that when speaking about the incident at charge 28.2 said words to the effect of "oh well she has had it and she is not dead yet." **[found proved]**

36. On 28 January 2019 when applying for a job at Blyth House put Barchester Healthcare as your present or most recent job when you knew that your present most recent employer was Chesterfield Royal Hospital. **[found proved]**

37. Your actions at charge 36 were dishonest in that at the time of making the application you sought to conceal that your present, most recent employer was Chesterfield Royal Hospital. **[found not proved]**

And in light of the above your fitness to practise is impaired by reason of your lack of competence in relation to charges 1 – 28 and by reason of your misconduct in relation to charges 29 - 37.

6 September 2021

The hearing recommenced on 6 September 2021 in accordance with the split scheduling of this hearing at which point the panel handed down its decision and reasons on the preliminary applications and the findings of facts on the charges.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Stevenson, on behalf of the NMC, to amend the numbering of the sub-charges under charge 27.

The proposed amendment was to correct a typographical error as there were two charges numbered 27.2. Ms Stevenson requested that the sub-charges under charge 27 be re-numbered to correct this and provide clarity.

You had no comment regarding the amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was satisfied that the amendment as applied for was justified and would not prejudice you. The panel therefore accepted the proposed amendment and renumbered charge 27 to remove the duplicated charge 27.2 and renumber the charges as appropriate.

Decision and reasons on the hearing being held in partly in private

At the outset of the hearing, the panel noted that there were references to your health and personal circumstances within the hearing papers.

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 determined to hold any parts of the hearing relating to your health and personal circumstances in private as and when such issues are raised in order to protect your privacy.

Decision and reasons on application to allow Ms 9 to give evidence with the webcam turned off

The panel heard an application made by Ms Stevenson to allow Ms 9 to give her evidence over video link with her webcam turned off. [PRIVATE].

You had no objection to Ms 9 attending with the webcam switched off.

The panel accepted the legal assessor's advice on the issues it should take into consideration in respect of this application.

The panel considered that, in the circumstances, it would be appropriate to allow Ms 9 to provide evidence with her webcam switched off. The panel therefore allowed the application.

Background

The charges in this case cover your employment as a registered nurse with five different employers between 2016 and 2019. The charges cover allegations around your lack of competence as well as your misconduct.

You came onto the NMC Register in March 2015. On 25 October 2015 you commenced work at Doncaster and Bassetlaw Hospital on Ward A4, a medical ward specialising in strokes and, from around January 2017, diabetes. It is alleged that several medication and clinical errors came to light and you were placed on a capability action plan in July 2016. This consisted of your practice being monitored and supervised. Colleague 1 was one of your supervisors during this time. Whilst you were under this capability action plan a number of incidents are said to have occurred and were discussed with you and recorded in supervision notes. These related to medication administration, record keeping, clinical practice and unprofessional behaviour. On 8 September 2017 you resigned from Doncaster and Bassetlaw Hospital without completing the capability action plan.

On 11 September 2017 you commenced employment as a nurse at Mallard Court Care Home (Mallard Court), a Barchester Care Home. It is alleged that on 26 July 2018 you were involved in an incident with a syringe driver which resulted in an investigation meeting with Ms 7 on 1 August 2018. Following this you transferred from Mallard Court to work as a nurse at Forest Hill Care Home (Forest Hill), another Barchester Care Home. Whilst working at Forest Hill several incidents are said to have occurred including medication administration errors and unprofessional behaviour. On 8 October 2018 you were suspended pending investigation.

On 9 October 2018 the Clinical Lead at Forest Hill, Ms 8, held an investigatory meeting with you. It is said that you were unprofessional during this meeting. On 19 October 2018 a further investigatory meeting was held this time with the Deputy General Manager, Ms 9. You were sent a letter on 24 October 2018 detailing that a disciplinary meeting was scheduled for 6 November 2018. On a date between 24 October and 6 November 2018 it is alleged that you behaved unprofessionally when speaking with the General Manager of Forest Hill, Colleague 4, and verbally handed in your resignation. You did not attend the disciplinary hearing which was held in your absence and a decision was made to terminate your employment. Your employment at Forest Hill officially ended on 6 November 2018, when your verbal resignation was accepted.

On 5 November 2018 you commenced employment as a staff nurse at Chesterfield Royal Hospital on Ashover Ward, a unit that specialised in endocrine medicine and the care of the elderly. You are said to have failed a medications competency assessment on 28 December 2018 and were placed on an action plan. On 10 January 2019 you passed your medications competency assessment. However, it is alleged that you made a subsequent medication error on the same day. Several incidents are said to have occurred at Chesterfield Royal Hospital in relation to your medication administration, and concerns were raised about your clinical knowledge, practice, patient care and unprofessional conduct. On 30 January 2019 you were placed on an action plan and were only permitted to work in a supernumerary capacity. You resigned from Chesterfield Royal Hospital on 24 March 2019.

On 28 January 2019 Ms 13 interviewed you for a position at Blyth Country House Care Home (Blyth House). On the interview form it is said that you declared that Barchester was your most recent employment and you did not declare your current employment at Chesterfield Royal Hospital.

On 1 April 2019 you commenced your employment at Blyth House. Concerns were raised regarding your competence and conduct on 15-16 April 2019. Your employment at Blyth House was terminated on 17 April 2019.

You are currently working as a nurse at Woodlands Nursing and Care Home (Woodlands) as Clinical Lead and Deputy Manager.

Decision and reasons on facts

Before making any findings on the facts, the panel accepted the advice of the legal assessor who referred to the cases of *Ivey v Genting Casinos [2017] UKSC 67* in respect of dishonesty and *Suddock v NMC 2015 EWHC 3612* and *Dutta v GMC [2020]* EWHC

1974 in respect of the approach the panel should take to the issue of the assessment of evidence of live witnesses. In addition, he invited the panel to have regard to the wording of the charges. The panel should consider the ordinary meaning of the charges and apply that meaning unless the evidence suggested that a different meaning should be ascribed to it.

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.

It considered the witness and documentary evidence provided by both the NMC and by you. The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Colleague 1 — Ward Sister on Ward A4 at Doncaster and Bassetlaw Teaching Hospital at the time of the incidents and one of your Supervisors.
- Colleague 2 — Inter-professional Clinical Educator at Chesterfield Royal Hospital NHS Foundation Trust.
- Colleague 3 — Clinical Lead at Blyth Country House Care Home at the time of the incidents.
- Colleague 4 — General Manager at Forest Hill Care Home at the time of the incidents.
- Ms 5 — Band 5 Staff Nurse on Ward A4 at Doncaster and Bassetlaw Teaching Hospital at the time of the incidents.
- Ms 6 — Clinical Site Manager at Doncaster and Bassetlaw Teaching Hospital.
- Ms 7 — Clinical Lead at Mallard Court Care Home at the time of the incidents.

- Ms 8 — Clinical Lead on Portland Suite at Forest Hill Care Home at the time of the incidents.
- Ms 9 — Clinical Deputy to the General Manager at Forest Hill Care Home.
- Ms 10 — Matron on Ashford Ward at Chesterfield Royal Hospital.
- Ms 11 — Senior Pharmacist Technician at Chesterfield Royal Hospital.
- Ms 12 — Band 5 Senior Nurse at Chesterfield Royal Hospital working on Ashford Ward at the time of the incidents.
- Ms 13 — Registered Nurse and Manager at Blyth Country House Care Home at the time of the incidents.
- Ms 14 — Ward Manager on Ward A4 at the time of the incidents.
- Ms 15 — Diabetes Specialist Nurse (DSN) at Doncaster and Bassetlaw Teaching Hospital at the time of the incidents.
- Ms 16 — Band 6 Ward Sister on Ward A4 at Doncaster and Bassetlaw Teaching Hospital at the time of the incidents.
- Relative B — Relative of Resident B, a resident at Forest Hill Care Home.

The panel also heard evidence from you under affirmation.

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

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

Charge 1.1

1. In or around June 2016 whilst working for Doncaster and Bassetlaw Hospital
    1.1. On becoming aware of Patient F's low urine output did not take any action.

This charge is found proved.

In reaching this decision, the panel took into account Ms 14's witness statement and oral evidence, Ms 14's email dated 9 June 2016, the file note of the meeting between you and Ms 14 on 9 June 2016 and your evidence.

In the email from Ms 14 on 9 June 2016 she details under the heading 'Capability' that there was a failure to recognise that a patient's low urine output for 36 hours was very serious.

The file note of the meeting on 9 June 2016 details that Ms 14 discussed with you a concern that you had not recognised the significance of no urine output for 36 hours. The panel noted that several concerns were identified and raised with you during this meeting and this led to you being placed on a capability action plan. The panel further noted that this file note was signed by you.

Ms 14 in her witness statement confirmed that you had failed to recognise that Patient F had no urine output for 36 hours.

In your evidence to the panel you said that you did not know anything about this charge. You also said that you would not have done a 36 hour shift so it could not solely be your responsibility to have recognised Patient F had no urine output for that length of time.

The panel considered Ms 14's evidence. The panel noted that Ms 14 had many contemporaneous records regarding the incidents which occurred and the support you were provided with. The panel found her evidence to be consistent with her contemporaneous records and her witness statement. The panel found her evidence to be clear, balanced and fair to you. Ms 14 told the panel that you had had the most support that she had ever provided to a nurse. The panel considered that her evidence was both credible and reliable.

The panel acknowledged your point that you would not have done a 36 hour shift, however, it considered that you should have recognised at some point during your shift

that a patient in your care had had so little urine output for a significant period of time regardless of whether a nurse on a previous shift should have picked up on it or not.

Having had regard to the contemporaneous record, which was signed by you in June 2016, and which was put to you in cross-examination, along with Ms 14's evidence the panel was satisfied that, on the balance of probabilities, in June 2016 whilst working at Doncaster and Bassetlaw Hospital, on becoming aware of Patient F's low urine output you did not take any action.

Accordingly this charge is found proved.

Charge 1.2

1.2. Were unable to manage a patient who was on sliding scale insulin.

This charge is found proved.

In reaching this decision, the panel took into account Ms 5's oral and written evidence, Ms 14's witness statement and oral evidence, Ms 14's email dated 9 June 2016, the file note of the meeting between you and Ms 14 on 9 June 2016 and your evidence.

In the email from Ms 14 on 9 June 2016 she details under the heading 'Capability' that you had failed to manage a patient on sliding scale insulin which would have serious implications.

The file note of the meeting on 9 June 2016 details that Ms 14 discussed with you a concern that you had not been able to manage a patient on sliding scale insulin. It was recorded that when questioned about the sliding scale insulin you stated that you did not know what to do but you could not give a satisfactory reason for why you had not spoken with the nurse in charge of the shift. The panel noted that several concerns were identified

and raised with you during this meeting and this led to you being placed on a capability action plan. The panel further noted that this file note was signed by you.

Ms 14 in her witness statement confirmed that Ms 5 had raised with her that you had been unable to manage a patient on sliding scale insulin. Ms 14 confirmed that Ms 5 had been the nurse in charge of the shift in question.

Ms 5 in her evidence explained that she was working a night shift on Ward A4 with you. She told the panel that she had become aware that one of your patients was on sliding scale insulin when a Health Care Assistant (HCA) approached her whilst you were on a break and asked her for assistance with the sliding scale insulin. When Ms 5 looked at the chart she noticed that the incorrect level of insulin was being given. Ms 5 explained to the panel how sliding scale insulin worked. Ms 5 said that she had checked with you on your return if you knew how to manage sliding scale insulin and that she showed you how to use the charts. She said she told you that you could come and ask her for help if you needed it before she returned to her own patients. Ms 5 also told the panel that you had given the impression that you did not require her advice.

In your evidence you disagreed with Ms 5's evidence. You told the panel that Ms 5 knew you had a patient on sliding scale insulin as she was beside you at the handover when this was discussed. You said that Ms 5 was '*very good at picking and choosing her teams/patients*'. You said that Ms 5 had known about the patient from the start of the shift and that she did not want to take that patient because she wanted to do her revalidation. You said Ms 5 sat at the desk all night apart from when she got up once between 04:00 and 05:00 to check '*the fluid'*. You said that you had asked Ms 5 at the start of the shift to go over sliding scales with you because you had not done one for a while and were not '*fully au fait with it'*. You repeatedly stated that Ms 5 was at the desk all night completing her revalidation.

When questioned, Ms 5 stated that she was not doing her revalidation that night. She denied that she would have sat at the desk all night doing this. She told the panel that she

was one of the last people to go through revalidation as revalidation was introduced from April 2016. She confirmed that she qualified in March 1998, she did her last annual registration update in March 2016, and that her first revalidation was due in March 2019. She told the panel that she had 13 patients of her own that she was looking after on that shift and that she had only received a handover in respect of her own patients. Ms 5 denied that she would have been able to choose her own patients and stated that the patients were allocated at the beginning of the shift.

During your evidence you continued to insist that Ms 5 had been doing her revalidation and that you had asked her for assistance but she was not willing to provide this. You were not willing to accept what Ms 5 said regarding her revalidation. You further added that you were also looking after a patient with haematemesis and another with delirium.

The panel considered Ms 5's evidence. The panel considered Ms 5 to be clear and consistent with the contemporaneous records. The panel considered that Ms 5 was fair to you, admitted when she could not remember, and conceded that with hindsight perhaps she should have helped you more on this shift.

The panel considered the conflict in evidence regarding revalidation. The panel noted that revalidation requirements were brought in in April 2016. It had regard to the fact that Ms 5 came onto the NMC Register in March 1998 and therefore would have been required to revalidate prior to March rather than in June as you have alleged. The panel considered Ms 5's evidence in respect of her revalidation to be credible. The panel accepted Ms 5's evidence and decided she was a credible and reliable witness in respect of her evidence.

The panel rejected your assertion that Ms 5 was sat at a desk completing her revalidation on this shift. It did not find your account credible or reliable. It noted that even when faced with substantial evidence to the contrary you maintained your view that Ms 5 was completing her revalidation. The panel therefore rejected your evidence in this regard.

Having had regard to the contemporaneous record, which was signed by you in June 2016, and which was put to you in cross-examination, along with Ms 5's and Ms 14's evidence the panel was satisfied that, on the balance of probabilities, in June 2016 whilst working at Doncaster and Bassetlaw Hospital, you were unable to manage a patient who was on sliding scale insulin.

Accordingly this charge is found proved.

Charge 1.3

1.3. Did not seek assistance and/or accept assistance regarding your inability to manage the patient who was on sliding scale insulin.

This charge is found proved.

In reaching this decision, the panel took into account Ms 5's oral and written evidence, Ms 14's witness statement and oral evidence, the file note of the meeting between you and Ms 14 on 9 June 2016 and your evidence as well as the panel's findings at charge 1.2.

The file note of the meeting on 9 June 2016 recorded that when questioned about the sliding scale insulin you stated that you did not know what to do but you could not give a satisfactory reason for why you had not spoken with the nurse in charge of the shift. The panel noted that several concerns were identified and raised with you during this meeting and this led to you being placed on a capability action plan. The panel further noted that this file note was signed by you.

In her evidence Ms 5 made it clear that she had told you on two occasions that you should ask her if you needed assistance with the sliding scale insulin. The second of these occasions was after she had independently checked the sliding scale insulin and found that you were still making and recording incorrect adjustments. Ms 5 said that you did not approach her at any point during that shift to inform her of any issues or ask any questions

regarding the sliding scale insulin. In her oral evidence she said that with hindsight she perhaps should have offered you support more proactively but that she was managing her own patients and considered you a colleague rather than someone who needed supporting.

You told the panel that you had asked Ms 5 for help on several occasions throughout the shift. You said that you had told Ms 5 that you were not '*fully au fait'* with sliding scale insulin and had asked Ms 5 to talk you through it. There is no record of this in the contemporaneous documentation.

As detailed in charge 1.2 the panel found Ms 5 to be a credible and reliable witness. Her evidence was clear and consistent with regard to this charge and was supported by the file note of the meeting on 9 June 2016 with Ms 14 which you signed.

The panel did not accept your account that you did ask Ms 5 for assistance but that she was too busy doing her revalidation to assist you. You painted a picture of Ms 5 sitting at a desk all night and not providing any care to her own patients whilst you were rushed off your feet with three patients who needed immediate attention and that you asked for assistance but were not provided with it. The panel did not find this to be credible.

Having had regard to the contemporaneous record, which was signed by you in June 2016, and which was put to you in cross-examination, along with Ms 5's and Ms 14's evidence the panel was satisfied that, on the balance of probabilities, in June 2016 whilst working at Doncaster and Bassetlaw Hospital, you did not seek assistance and/or accept assistance regarding your inability to manage the patient who was on sliding scale insulin.

Accordingly this charge is found proved.

Charge 1.4

1.4. Were unable to recognise the significance of a patient having haematemesis.

This charge is found proved.

In reaching this decision, the panel took into account Ms 6's oral and written evidence, Ms 14's witness statement and oral evidence, Ms 14's email dated 9 June 2016, the file note of the meeting between you and Ms 14 on 9 June 2016 and your evidence.

In the email from Ms 14 on 9 June 2016 she details under the heading 'Capability' that you had failed to recognise that '*a patient who is vomiting blood [haematemesis] is a medical emergency*'.

The file note of the meeting on 9 June 2016 recorded that you had not been able to recognise the significance of a patient having haematemesis. The panel noted that this was the third of several incidents of concern that were identified and raised with you during this meeting. This led to you being placed on a capability action plan at this meeting. The panel further noted that this file note was signed by you.

In her evidence Ms 6 said that it came to her attention during a ward round that you had failed to recognise the significance of a patient with haematemesis. She said that when she spoke to you about this you had told her it was nothing to worry about and that you did not seem bothered about it. She said that she got the impression that you did not think you needed to take the patient's blood pressure but that this should have been done, along with other observations, in response to haematemesis. Ms 6 said she did not know if you did not realise that you needed to do the observations straight away or get another nurse to do so, or if you could not be bothered. She explained that she eventually took the patient's blood pressure herself with a HCA and notified a doctor to come and look at the patient.

In her evidence Ms 14 explained that Ms 6 had informed her that there had been a patient with haematemesis but that you had not completed or recorded observations. Ms 14 said

that Ms 6 had been concerned that you had not recognised the significance of the patient's condition.

In your evidence in chief you said that the patient did have haematemesis and that this was highlighted, you said that Ms 5 was sat at the desk and chose not to help you. You said that there was not a lot of blood in the bowl and that your priority had been the patient in the next bay with a 'hypo'. You said you asked a HCA to do observations on this patient but that they were not done.

In her evidence Ms 5 had said that you did not request assistance from her on this shift as detailed in charges 1.2 and 1.3 above.

Under cross-examination you said that you *'put your hands up that you didn't get his obs done straight away as you needed to sort out the other patient who was having a hypo first'*. You said that you did recognise the significance of the patient's condition. You said you spoke to Ms 5 and you phoned for a doctor which you claim is why Ms 6 came to the ward. You said that you were not overly concerned as there was not much blood in the bowl. You said you found it offensive that Ms 6 had portrayed you as that you did not care.

The panel considered Ms 6's evidence. It was clear to the panel that Ms 6 had concerns regarding your practice. She was able to provide the panel with a clearer picture of the context within which you were working, she described a supportive culture with no systemic issues. Her evidence was corroborated by Ms 14's evidence and the contemporaneous documentary evidence. The panel was satisfied Ms 6's evidence was credible and reliable. It noted that she had been concerned enough about this incident that she had felt it necessary to raise it formally with Ms 14.

The panel considered that your account was confused and changed between your evidence in chief and under cross-examination the next day.

Having had regard to the contemporaneous record, which was signed by you in June 2016, and which was put to you in cross-examination, along with Ms 6's and Ms 14's evidence the panel was satisfied that, on the balance of probabilities, in June 2016 whilst working at Doncaster and Bassetlaw Hospital, you were unable to recognise the significance of a patient having haematemesis.

Accordingly this charge is found proved.

Charge 2.1

2. On an unknown date whilst working for Doncaster and Bassetlaw Hospital in relation to a patient whose airways were occluding:
   2.1. did not press the emergency buzzer.

This charge is found proved.

In reaching this decision, the panel took into account Ms 14's oral and written evidence and your evidence.

In her evidence Ms 14 detailed an incident in which a critical care nurse had shouted for her to assist her with a patient whose airway was occluding. Ms 14 said that when she arrived in the room the patient was struggling to breathe and you were stood at the side of the bed crying. Ms 14 said that you had not pulled the buzzer to summon assistance as she would have heard this in her office and she did not hear a buzzer at all during that shift.

Under cross-examination you admitted that you did not press the emergency buzzer in relation to a patient whose airway was occluding as you were not in the room but then your account of this appeared to shift to a different event and patient. The panel found your evidence regarding this charge to be confused. The panel was therefore unable to

place much weight on your evidence in respect of this charge and preferred the consistent evidence of Ms 14.

The panel concluded that, on the balance of probabilities, on an unknown date whilst working for Doncaster and Bassetlaw Hospital, in relation to a patient whose airways were occluding, you did not press the emergency buzzer.

Accordingly this charge is found proved.

Charge 2.2

2.2. did not alert other members of staff.

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 14's oral evidence.

Ms 14 accepted in her oral evidence that you must have sought some assistance given that the critical care nurse had been in the room. The panel therefore concluded that the NMC had not discharged its burden of proof regarding this charge.

Accordingly this charge is found NOT proved.

<u>Between July 2016 and February 2017 whilst on a capability plan with the Doncaster and Bassetlaw Hospital:</u>

Charge 3.1

3. On 13/14 July 2016 in relation to Patient G who was experiencing a hypoglycaemic episode:

3.1. Administered/or allowed more than one glucagon injection to be administered to the patient.

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient G's notes, the Datix relating to this incident, dated 14 July 2016, Ms 15's and Ms 14's evidence as well as your evidence.

Ms 15 said that she could see from Patient G's records that the staff on duty had given Patient G oral Dextrogel, followed by three Glucagon injections. Glucagon is an emergency medication used to treat hypoglycaemia (dangerous low blood sugar) in diabetic patients. Ms 15 said that she believed it was Ms 14 who had informed her that you were on this shift. She could not recall the names of any other staff on this shift.

In her evidence Ms 14 said that a Datix was completed by Ms 15 on 14 July 2016 in relation to Patient G who experienced a severe hypoglycaemic episode. Ms 14 said that you failed to follow the hypoglycaemic protocol properly.

The panel had regard to the Datix relating to this incident, dated 14 July 2016. The panel noted that it says that several staff were involved in this incident but it does not name any of the staff.

You said that you had no recollection of this happening and that you would not knowingly give or allow someone to be given more than one Glucagon injection. You said that you could not answer any questions in relation to this as you do not remember anything about it.

The panel was not satisfied from the documents before it that there was sufficient evidence to support this charge. The contemporaneous documentation does not name you in relation to this incident, nor have you signed any of the records exhibited from this shift. The only evidence that places you there comes from Ms 15's and Ms 14's witness

statements which are dated 10 February 2020 and 20 May 2021 respectively, almost four and five years after the event in question. The panel considered it possible that Ms 15 and Ms 14 could be mistaken over who was present at this incident when writing their NMC witness statements so long after the event. Without contemporaneous evidence to support it, the panel concluded that the NMC had not discharged the burden of proof in respect of this charge.

Accordingly this charge is found NOT proved.

Charge 3.2

3.2. Did not bleep the on call anaesthetist to attempt cannulation on the patient.

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient G's notes and its findings at charge 3.1.

The panel had regard to Patient G's notes from 14 July 2016 timed at 05:50 in which it states '*…bleeped anaesthetist…*'. The panel therefore concluded that someone did bleep the anaesthetist although it has heard no evidence as to who that was and the signature is not clear.

You said that you do not remember anything about this incident.

The panel reminded itself of its finding at charge 3.1 and the lack of evidence to support that you were on duty on this date or involved in this incident.

The panel therefore concluded that there was insufficient evidence to support this charge.

Accordingly this charge is found NOT proved.

Charge 3.3

3.3. Were unable to locate where the glucagon was kept on ward A4.

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient G's notes, the Datix relating to this incident, dated 14 July 2016, Ms 15's and Ms 14's evidence as well as your evidence.

Ms 15 said that she could see from Patient G's records that the staff on duty had been unable to locate where the Glucagon was kept on the ward.

In her evidence Ms 14 said that a Datix was completed by Ms 15 on 14 July 2016 in relation to Patient G who experienced a severe hypoglycaemic episode. Ms 14 said that you were unable to locate where the Glucagon was kept on ward A4.

The panel had regard to the Datix relating to this incident, dated 14 July 2016. The panel noted that it says that several staff were involved in this incident but it does not name any of the staff.

The panel had regard to Patient G's notes from 14 July 2016 timed at 05:50 in which it states *'…no Glucagon on ward…'*. Again it was not clear who had written this in Patient G's notes.

You said that you could not answer to this as you do not remember anything about it.

The panel reminded itself of its finding at charge 3.1 and 3.2 and the lack of evidence to support that you were on duty on this date or involved in this incident.

The panel therefore concluded that, whilst it would appear that someone was not able to locate Glucagon on ward A4, there was nothing to support the allegation that this was you.

Accordingly this charge is found NOT proved.

Charge 3.4

3.4. Administered Dextrogel as a first option which was not correct as the patient was experiencing a severe hypoglycaemic episode.

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient G's notes, Ms 15's and Ms 14's evidence as detailed above as well as your evidence.

You said that you had no recollection of this.

The panel reminded itself of its findings at charges 3.1, 3.2 and 3.3 and the lack of evidence to support that you were on duty on this date or involved in this incident.

Given the lack of contemporaneous evidence that you were on shift the panel therefore concluded that there was insufficient evidence to support this charge.

Accordingly this charge is found NOT proved.

Charge 4.1

4. On 22 July 2016 on being informed that Patient H was experiencing a hypoglycaemic episode:
   4.1. Did not provide immediate assistance.

This charge is found proved.

In reaching this decision, the panel took into account Patient H's notes, the Datix relating to this incident, dated 22 July 2016, Ms 15's and Ms 16's oral and written evidence as well as your evidence.

In her evidence Ms 15 told the panel that on 22 July 2016 she was on the ward at the nurse's station discussing a diabetic patient with you when a HCA approached you and told you that Patient H had a blood glucose level of 1.8mmols. Ms 15 told the panel that the HCA said she would give the patient orange juice and you responded OK and carried on speaking with her. Ms 15 said she had to tell you that Patient H was experiencing a severe hypoglycaemic episode and that you needed to assess Patient H and treat her properly. You then went to see Patient H. Ms 15 said that you should have dropped everything and gone to the patient immediately. She then asked Ms 16 to check that you were treating Patient H appropriately.

In her evidence Ms 16 said that Ms 15 brought it to her attention that Patient H had a reported blood glucose level of 1.8mmols, that you had carried on with what you were doing rather than going to assess the patient and that you had to be prompted to go and assess Patient H. Ms 16 then went to assess Patient H herself, having overheard what was going on and on being asked by Ms 15 to assist. She said that Patient H was slumped in a chair with a reduced level of consciousness. Ms 16 then detailed how she treated Patient H.

The panel had regard to the Datix relating to this incident, dated 22 July 2016, which was completed by Ms 16 on the same day as the incident and in which you are named. In the description it states:

> *'Staff nurse MS [you] was informed by HCA that [Patient H's] blood glucose level was 1.8mmols whilst she was at the nurse station liaising with DSN [Ms 15]. DSN informed me that the healthcare had stated that she would give her orange juice to*

resolve the hypoglycaemic episode, staff nurse MS said 'ok' and carried on what she was currently doing. DSN informed staff nurse MS that she needed to go and assess the patient and treat the episode. DSN informed me of this and asked if I would go and assess the patient which I was on my way to do as I had already overheard what was happening. As I approached the patient she was slumped in a chair with a reduced level of consciousness, I administered oral dextrogel and informed SN MS to get Glucagon – she stated she did not know what this was and started to take down the foot dressing. Prior to [this] she had administered a full bottle of Lucozade as a treatment. I asked a HCA to recheck the [blood glucose level] and it was only 1.9 mmols. I administered Glucogon (sic) as per protocol.'

In your evidence in chief you told the panel that you could not answer this as you did not remember anything about this incident. However, under cross-examination the following day you told the panel that you were writing notes at the desk when the HCA approached you and said that the blood glucose level reported was 3.8mmols. You told the panel that you literally wrote down what you had to in the patient notes and that you followed the HCA within seconds. The panel considered that your evidence was inconsistent and implausible as your position had altered overnight from having no recall to having clear recall of exactly what you had been doing and remembering a precise blood glucose result. Therefore it considered your evidence could not be relied on in respect of this charge.

The panel preferred the evidence of Ms 15 and Ms 16 which was corroborated by the contemporaneous record of the incident in the Datix as well as by each other's account. The panel considered that their evidence was clear and consistent. It concluded their evidence was both credible and reliable.

The panel concluded that, on the balance of probabilities, on 22 July 2016 on being informed that Patient H was experiencing a hypoglycaemic episode you did not provide immediate assistance.

Accordingly this charge is found proved.

Charge 4.2

4.2. Gave the patient Lucozade which was incorrect as the patient had a reduced level of consciousness.

This charge is found NOT proved.

In reaching this decision, the panel took into account to Patient H's notes, the Datix relating to this incident, dated 22 July 2016, Ms 15's and Ms 16's oral and written evidence as well as your evidence.

In her evidence Ms 15 told the panel that Ms 16 had told her when she returned from seeing Patient H that you had given the patient Lucozade. Ms 15 said she that she knew that the patient had a reduced level of consciousness as it was recorded in the Datix and that giving Lucozade would have been incorrect as it would have been a choking risk.

In her evidence Ms 16 said that, whilst Lucozade is mentioned in the Datix, she had no recollection of seeing Lucozade being administered and she did not know how she knew Lucozade had been given.

You said you did not remember this.

The panel considered that it has heard no evidence from anyone that you were seen giving Lucozade to the patient whilst they were experiencing a reduced conscious level. The panel noted that this is detailed in the contemporaneous statement but Ms 16 has admitted she did not see you do this and that she has no recollection of how she knew this at the time. Further Ms 15 only knew this from Ms 16. The panel did not consider the evidence in respect of this charge to be reliable.

Accordingly this charge is found NOT proved.

Charge 4.3

4.3. Were unaware of what the medication glucagon was for.

This charge is found proved.

In reaching this decision, the panel took into account to Patient H's notes, the Datix relating to this incident, dated 22 July 2016, Ms 16's oral and written evidence as well as your evidence.

In her evidence Ms 16 said that she had asked you to get Glucagon and you responded that you did not know what Glucagon was.

This was supported by the Datix relating to this incident, dated 22 July 2016 and completed by Ms 16. In the description it states:

> *'…. As I approached the patient she was slumped in a chair with a reduced level of consciousness, I administered oral dextrogel and informed SN MS to get Glucagon – she stated she did not know what this was and started to take down the foot dressing. … I asked a HCA to recheck the [blood glucose level] and it was only 1.9 mmols. I administered Glucogon (sic) as per protocol.'*

You denied that you did not know what Glucagon was for.

The panel considered that there was clear, contemporaneous evidence that you did not know what Glucagon was for. You are named in the Datix and Ms 16's evidence is consistent with this contemporaneous record. The panel further noted that this Datix and your lack of appropriate response to Patient H's hypoglycaemic episode was what initiated the decision to put you on a performance management programme.

The panel therefore concluded that, on the balance of probabilities, on 22 July 2016 on being informed that Patient H was experiencing a hypoglycaemic episode you were unaware of what the medication Glucagon was for.

Accordingly this charge is found proved.

Charge 4.4

4.4. Incorrectly prioritised the patient's foot dressing over the patient's hypoglycaemic episode.

This charge is found proved.

In reaching this decision, the panel took into account to Patient H's notes, the Datix relating to this incident, dated 22 July 2016, Ms 16's oral and written evidence as well as your evidence.

In her evidence Ms 16 said that she had asked you to get Glucagon and you responded that you did not know what Glucagon was and instead started to take down the patient's foot dressing. She told the panel that you continued to deal with the patient's foot dressing whilst she and the HCA dealt with the hypoglycaemic episode. She told the panel that your priority should have been to deal with the patient's low blood sugar as the risk of harm to the patient from this was very high.

The panel had regard to the Datix relating to this incident, dated 22 July 2016. In the description it states *'…. [I] informed SN MS to get Glucagon – she stated she did not know what this was and started to take down the foot dressing. ...'*

You said this was not the case and that your priority would have been the hypoglycaemic episode. You told the panel that a lot of Datix's were '*flying in'* but no one spoke to you about it.

The panel again preferred Ms 16's evidence on this charge which is clearly supported by the contemporaneous record in the Datix. The panel noted your statement that no one spoke to you about the various Datix reports but considered that someone must have spoken to you about these as these formed the basis of the decision to put you on a performance management programme.

The panel therefore concluded that, on the balance of probabilities, on 22 July 2016 on being informed that Patient H was experiencing a hypoglycaemic episode you incorrectly prioritised the patient's foot dressing over the patient's hypoglycaemic episode.

Accordingly this charge is found proved.

Charge 5

5. On 25 July 2016 following handover from the night shift in relation to Patient I did not familiarise yourself with the IV pumps.

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient I's notes, the Datix relating to this incident, dated 25 July 2016, Ms 15's oral and written evidence as well as your evidence.

The panel had regard to the Datix, dated 25 July 2016 and completed by Ms 15. Under Root Causes it states '*Blood sugar recorded by bank CSW at 0700 who then did not relay the reading to Staff nurse who was in handover. Nurse did not review pump after handover'.* The panel noted that you are not named in the Datix. However, you have signed Patient I's notes at 08:00 on 25 July 2016. The panel therefore concluded that you were on the day shift and caring for Patient I.

In her evidence Ms 15 said that it was best practice to prioritise familiarising yourself with the IV pumps when coming on shift and that you had not done this.

You told the panel that you could not answer to this charge as you did not remember anything about it.

The panel noted that you were likely handed over this patient's care at some point between 07:00 and 08:00 as you have written in Patient I's notes at 08:00 but it was a bank HCA who checked the patient's blood glucose at 07:00. It noted that in the Datix it clearly states that the blood glucose reading from 07:00 was not handed over to you by that HCA.

The panel concluded that it would not have been unreasonable for your first check of Patient I's IV pump to have been at 08:00 as it had no indication of when the nightshift handover had been completed. Therefore there is no indication of when the responsibility for this patient was transferred to you and you were not provided with a full handover of information. Whilst it was clear to the panel that a mistake had been made, it did not consider that you were solely responsible.

The panel concluded that there was insufficient evidence before it to prove this charge.

Accordingly this charge is found NOT proved.

Charge 6

6. On 1 August 2016 did not provide Patient J with any TTO's upon discharge.

This charge is found NOT proved.

In reaching this decision, the panel took into account to Patient J's notes, the Datix relating to this incident, dated 6 August 2016, Ms 14's and Colleague 1's oral and written evidence as well as your evidence.

The panel had regard to the Datix, dated 6 August 2016 in relation to an incident on 1 August 2016 reported by Colleague 1. Under Description it states:

> '*Patient left ward to nursing home with full bag of TTO's – I had checked with SN (MS) [you] that everything was ready for discharge and she state yes. Patient left with TTO bag, feed and pumps, transfer letter and discharge letter. It came to my attention that the care home phoned the next day to say she had been sent home without insulin, notes checked and no TTO's were checked prior to discharge – no TTO letters had even been printed off. Patient had no insulin for d/c and as a result was not given the doses prescribed*.'

In her oral evidence Colleague 1 confirmed that the only TTO that was missing was insulin.

You told the panel that you could not answer to this charge as you did not remember anything about it.

The panel considered the evidence before it which is clear that you did not include insulin in the TTO's for Patient J upon discharge which could have had a serious impact upon the patient. However, it is also clear that you did provide Patient J with the rest of the TTO's required. Therefore the panel could not find this charge proved.

Accordingly this charge is found NOT proved.

Charge 7

7. On 10 October 2016 on conducting a handover did not provide the full details of one patients care plan.

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 10 October 2016, Ms 14's and Colleague 1's oral and written evidence as well as your evidence.

The panel had regard to the supervision notes dated 10 October 2016 which were signed by Colleague 1 and you. It is stated:

> '*Maggie felt that I had informed the night staff of an issue before she had a chance to handover. I explained that the doctor had changed the medical plan and discussed this with me. I was just informing the night staff so they had an accurate handover*'.

In her evidence Colleague 1 was clear that she had information which you did not have and confirmed that there was no error on your part in not handing over information which you did not know.

In your evidence you questioned how you could have handed something over if you had not been given the information.

The panel considered that the evidence before it is clear that on 10 October 2016 you did not provide the full details of one patients care plan when conducting a handover although it accepted that this was because you were not aware of the full, updated details of the care plan.

The panel therefore found this charge proved on a factual basis.

Charge 8

8. On 11 October 2016 in relation to a patient who was unwell with chest pain
    8.1. did not conduct a full set of observations. **[found NOT proved]**
    8.2. did not contact the doctor on duty. **[found NOT proved]**
    8.3. did not inform the nurse in charge. **[found proved]**
    8.4. did not perform an ECG. **[found NOT proved]**
    8.5. did not ask for assistance to conduct an ECG. **[found NOT proved]**

This charge is found NOT proved in relation to charges 8.1, 8.2, 8.4 and 8.5. This charge is found proved in respect of charge 8.3.

The panel decided to consider these charges together.

In reaching this decision, the panel took into account the signed supervision notes dated 10 October 2016, Colleague 1's oral and written evidence as well as your evidence.

In her evidence Colleague 1 told the panel that there had been a patient who was acutely unwell with chest pain during the shift. She said the correct response would have been to conduct a full set of observations, contact the doctor on duty, inform the nurse in charge and perform an ECG. If someone was not confident in performing an ECG they should ask for assistance. Colleague 1 said that you did not respond to this patient having chest pain or raise concerns with another member of staff.

The panel had regard to the supervision notes dated 11 October 2016 which were signed by Colleague 1 and you as a true reflection of that day's supervised practice. In this it is stated '*Patient acutely unwell on ward with chest pain discussed informing the nurse in charge if there was a concern with patient as this had not been done today.'* The panel noted that this was the only entry relating to a patient who was unwell with chest pain. There is no record relating to conducting observations, contact the doctor on duty, performing an ECG or not asking for assistance to conduct an ECG.

In your evidence to the panel you admitted that you did not inform the nurse in charge. You said that the nurse in charge was not available on the ward so you had sent a student to find her and you stayed with the patient who was your priority. You said that you did a full set of observations, that you had given GTN spray, that you had contacted the doctor and that you were putting the ECG on and asked Colleague 1 a question to clarify that what you were doing was correct. You told the panel that Colleague 1 had given you a '*barrage of abuse'* when you asked for assistance and that you felt that no matter what you did it was never good enough for Colleague 1. You told the panel that you felt bullied and that you had raised a complaint but that this was never logged.

In her evidence Colleague 1 addressed the issue of you feeling bullied and your allegation of a bullying culture on the ward. She told the panel that she did not know why you felt this way, she said her role was to supervise you and to support you to enable you to complete your supernumerary period and to practise safely. She told the panel that you had been offered other supervisors but that you had said you were content to be supervised by her and another named nurse.

The panel noted that Colleague 1 recorded when you did things well within the supervision notes as well as recording errors. In her oral evidence Colleague 1 reassured you of her support at the time and encouraged you to ask questions of her to ensure you got a fair chance at cross-examination of her witness evidence. The panel did not get an impression of any ill will towards you from Colleague 1.

The panel has reviewed all of the supervision notes by Colleague 1 and has concluded that her contemporaneous notes were detailed and thorough. The panel noted that the only one of the charges under charge 8 that is detailed in the contemporaneous records is that you did not inform the nurse in charge of a patient who was unwell with chest pain (charge 8.3). This is also a charge you have admitted. The panel therefore concluded that charge 8.3 is proved.

However, the panel considered that there is insufficient evidence to support the remaining charges. It considered that if Colleague 1 had specific concerns regarding this she would have documented this in the supervision notes for that day. There is nothing in the supervision notes to support the allegations that you did not do observations, contact the duty doctor or perform an ECG. The panel concluded that Colleague 1 may have been mistaken in her recollection of the precise details of this incident.

The panel preferred your evidence in this regard as it was supported by the contemporaneous records which were signed and dated on the day. You were clear and consistent in your evidence that you did do these things.

Accordingly this charge is found proved in respect of charge 8.3 only and found NOT proved in relation to charges 8.1, 8.2, 8.4 and 8.5.

Charge 9

9. On 4 November 2016 on preparing the blood glucose monitor to check a patient's blood sugar level selected a venous sample for collection rather than a capillary.

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 4 November 2016, Colleague 1's oral and written evidence as well as your evidence.

In her evidence Colleague 1 told the panel that during supervised practice on 4 November 2016 you had started to prepare the blood glucose monitor to check a patient's blood sugar level. When she checked the monitor she noticed that instead of selecting the capillary sample (which was the setting used when the blood for the sample is collected via a finger prick) you had selected the venous sample option (which would be used if blood had been taken directly from a patient's vein). She told the panel you were not trained to take venous samples. She confirmed that you proceeded to take the blood

sample using the capillary method however she was concerned that you had selected the wrong option on the blood glucose monitor.

The panel had regard to the supervision notes dated 4 November 2016 and which were signed by Colleague 1 and you as a true reflection of that day's supervised practice. In this it is stated:

> '*Maggie started to prepare the blood glucose monitor to check a patient's blood sugar. Maggie was inputting the patient's information when I checked the monitor Maggie had chosen venous sample for collection rather than capillary. We went through together setting up the monitor and Maggie went to take the sample without washing the patient's finger. After been reminded Maggie took the sample and processed it correctly*.'

The panel concluded that this corroborated Colleague 1's witness evidence.

The panel considered your evidence on this charge to be confused and evasive. You talked about ketone strips and of the strips being in the wrong place in the kit. The panel was clear that this was not the issue and that your evidence was about something else entirely. The issue in this charge was that you had selected the wrong setting on the blood glucose monitor.

The panel therefore preferred Colleague 1's evidence which was supported by contemporaneous documentation.

The panel concluded that, on the balance of probabilities, on 4 November 2016 on preparing the blood glucose monitor to check a patient's blood sugar level you selected a venous sample for collection rather than a capillary.

Accordingly this charge is found proved.

Charge 10

10. On 4 November 2016 on being aware that a patient should receive a reading ten minutes after treatment is provided stated to Colleague 1 words to the effect of “in 10 minutes but I’m not going to do it then because it won’t have had the chance to go up as yet.”

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 4 November 2016, Colleague 1’s oral and written evidence as well as your evidence.

In her evidence Colleague 1 told the panel that during supervised practice on 4 November 2016 she had also had to discuss the hypoglycaemia protocol with you. She said that when she questioned you on what time the next blood glucose level measurement would be checked, you said ‘*In ten minutes but I am not going to do it then because it will not have had a chance to go up yet’*. She told the panel that the Hypoglycaemia Policy was clear that a blood glucose reading needed to be taken ten minutes after treatment was provided. She said that by this stage you had received multiple training sessions on the hypoglycaemia protocol and should have known the importance of a blood glucose (bm) reading being taken ten minutes after treatment.

The panel had regard to the supervision notes dated 4 November 2016 and which were signed by Colleague 1 and you as a true reflection of that day’s supervised practice. These state:

> ‘*Maggie put the bm reading on the document and documented the treatment. The next step was to take another reading in 10 minutes as policy. I questioned Maggie on what time the next bm check was due and she told me "In 10minutes but I'm not going to do it then because it won't have had chance to go up yet." I explained to Maggie she will need to follow the hospital policy and procedure and take the blood*

sugar as policy. If the blood sugar had not risen we need to follow the next step until it comes back into range.'

In your evidence you disputed that you had said those words and said that Colleague 1 had misinterpreted you. You told the panel that you were questioning the policy as sometimes readings do not change much in ten minutes and you were asking if there was a way to change the policy. You said that it was a simple question and that it had been blown out of proportion to make you '*look like a heinous criminal'*. You said it was not that you were refusing to check it after ten minutes and that you did it as per the protocol.

The panel considered that Colleague 1's evidence was consistent and corroborated by contemporaneous documentation which you have signed as a true reflection of that day's supervision. There was no note in the supervision record to support your assertion that you were questioning policy when you said the words recorded.

The panel concluded that, on the balance of probabilities, on 4 November 2016 on being aware that a patient should receive a reading ten minutes after treatment is provided you stated to Colleague 1 words to the effect of *"in 10 minutes but I'm not going to do it then because it won't have had the chance to go up as yet."*

Accordingly this charge is found proved.

Charge 11

11. On 21 November 2016 did not complete 15 minute observations on a patient who had had a blood transfusion.

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 21 November 2016, Colleague 1's oral and written evidence as well as your evidence.

In her evidence Colleague 1 said that she had had to intervene to ensure that appropriate observations were carried out on a patient receiving a blood transfusion. She said she had to remind you of the importance of conducting observations 15 minutes after a new bag of blood was administered for the transfusion and explained why this was required and the risks involved in blood transfusions. She told the panel that Ms 14 had already spoken to you about the importance of completing observations when this patient had their first infusion as you had not completed the observations then. This incident related to the patient's second blood transfusion.

Colleague 1's evidence was supported by the contemporaneous record of supervision on 21 November 2016 which was signed by Colleague 1 and you. It states:

> '*Maggie had discussed the blood transfusion with [Ms 14] as she didn't realise she had to complete 15 minute observations after the infusion had started… When the gentleman needed his second infusion I asked Maggie if the 15 minute observations had been done. She stated she hadn't had time*.'

You told the panel you had no recollection of this incident.

The panel was initially concerned that the wording of the charge may be interpreted as what was being complained about was a failure to observe a patient after a blood transfusion had been completed. However, the evidence involved a complaint that the patient should have been provided with 15 minute observations during the course of the transfusion.

The panel had careful regard to the sequence of events that took place. It was noted that you had been advised by Ms 14 that 15 minute observations were required after an infusion started. It was a concern that you had not carried out observations during the first transfusion. In the context of the charge this concern (relating to the first transfusion) does not give rise to an allegation of lack of competence. Colleague 1's evidence was that you

failed to carry out these observations after the second infusion commenced. This charge arises because despite both Ms 14 and Colleague 1 reminding you of your responsibility to conduct these observations you did not do so.

The panel considered that there was clear evidence that you did not complete observations on a patient who had already had one transfusion despite being spoken to about the importance of doing so in the time between the two transfusions.

The panel therefore concluded that on 21 November 2016 you did not complete 15 minute observations on a patient who had had a blood transfusion.

Accordingly this charge is found proved.

Charge 12

12. On 24 November 2016 in relation to an unknown patient dispensed 20mg of omeprazole when the correct dose was 40mg.

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 24 November 2016 as well as your evidence.

Under cross-examination you accepted this charge. You said you '*put [your] hands up to that one*', that you only gave one tablet not two and that you did not know why.

This was supported by the contemporaneous note in the supervision record, dated 24 November 2016 and was signed by Colleague 1 and you, which states '*1x omeprazole missed – dispensed 20mg patient required 40mg'*.

The panel accepted your admission which was supported by the contemporaneous documentation and therefore found this charge proved.

Charge 13

13. On 24 November 2016 in relation to an unknown patient:
    13.1. Did not recommence IV KCL.
    13.2. Did not seek assistance to recommence IV KCL.

This charge is found proved in its entirety.

The panel considered charges 13.1 and 13.2 together.

In reaching this decision, the panel took into account the signed supervision notes dated 24 November 2016, Colleague 1's oral and written evidence as well as your evidence.

In her evidence Colleague 1 said that the IV KCL (intravenous fluid containing potassium) had not been recommenced after it had been disconnected to allow the patient to go for a scan. She said that it should have been recommenced as soon as the patient returned to the ward as otherwise they would not be receiving their medication. Colleague 1 told the panel that you had completed your training on IVs (also referred to as a package) and therefore you should have been able to do this. She said if you were not confident in dealing with this you should not have disconnected the patient.

This was supported by the contemporaneous note in the supervision record, dated 24 November 2016 and was signed by Colleague 1 and you, which states:

> '*Patient on IV KCL via central line - patient went for scan and was disconnected. When I checked on patient later on after scan no IVF had been recommenced. I discussed prioritising patients with Maggie as this patient is unwell and for full*

active treatment. Maggie said she didn't do central lines. I explained even if she doesn't feel confident in completing this task. I am here to support. It is important that we communicate to ensure the patient receives the plan of care. Maggie has completed her package and we can look at central line care over the next couple of days with this patient.'

You told the panel that you could not remember this incident.

The panel was satisfied, on the basis, of the signed contemporaneous record, that on 24 November 2016 in relation to an unknown patient you did not recommence IV KCL and you did not seek assistance to recommence IV KCL.

Accordingly the panel found charges 13.1 and 13.2 proved.

Charge 14

14. On 24 November 2016 when drawing up flushes and water for injections:
    14.1. Did not clean the sterile water vials.
    14.2. did not clean the glass water bottles.

This charge is found proved in its entirety.

The panel considered charges 14.1 and 14.2 together.

In reaching this decision, the panel took into account the signed supervision notes dated 24 November 2016, Colleague 1's oral and written evidence as well as your evidence.

In her evidence Colleague 1 told the panel that you had failed to clean the sterile water vials and the glass bottles before you drew up flushes and water for injection. She explained that the appropriate aseptic technique would be to clean these first to avoid contamination risk.

This was supported by the contemporaneous note in the supervision record, dated 24 November 2016 and was signed by Colleague 1 and you, which states:

> '*I have supervised Maggie with the IVAB today. Maggie has completed package when Maggie started to draw up the flushes and water for injection she did not clean them first. I told her they needed cleaning prior to them being draw up. Maggie said "well nobody else bothers so why should I?" I explained Maggie is on supervised practice and I would expect that she followed policies and procedures. My expectation is that she follows the policy and to remember that we are monitoring her competencies, attitudes and professional behaviours.'*

Initially in your evidence you told the panel that you did not know if you did or did not clean these. However, in cross-examination you admitted that you did not clean them, blaming Colleague 1 for putting you on edge.

The panel was satisfied, on the basis of the evidence before it, that on 24 November 2016 when drawing up flushes and water for injections you did not clean the sterile water vials and you did not clean the glass water bottles.

Accordingly this charge is found proved.

Charge 15

15. On 25 November 2016 did not use IVAB labelling.

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 25 November 2016, Colleague 1's oral and written evidence as well as your evidence.

In her evidence Colleague 1 told the panel that she had had to remind you to use IVAB labelling despite already having had a discussion with you about the importance of IVAB labelling that morning.

This was supported by the contemporaneous note in the supervision record, dated 25 November 2016 and was signed by Colleague 1 and you, which states:

> '*Am - We have discussed labelling IVAB to ensure Maggie is clear on what IVAB have been drawn up.*
> *Afternoon - IVAB drawn up again Maggie did not use labels as discussed am, reminded again.*'

Initially in your evidence you told the panel that you did not know if you did or did not use IVAB labelling. However, in cross-examination the following day you said that your previous evidence was wrong, that when you sat down and looked through the documents overnight your memory had come back to you. You said that you had had a conversation with Colleague 1 about labelling IVAB and that you did label it because she countersigned it. The panel considered your evidence to be unreliable. Your evidence changed overnight and was not supported by a contemporaneous record.

The panel preferred Colleague 1's evidence which was supported by the contemporaneous supervision note which was signed by you as well as her. The panel had no reason to believe that Colleague 1 was lying or would have recorded something which did not happen. It considered her to be both credible and reliable and to have done her best to support you.

The panel was satisfied, on the basis of the evidence before it, that on 25 November 2016 you did not use IVAB labelling.

Accordingly this charge is found proved.

Charge 16

16. On 25 November 2016 in relation to an unknown patient dispensed 1mg of prucalopride when the correct dose was 3mg procholperazine.

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 25 November 2016, Colleague 1's oral and written evidence as well as your evidence.

In her evidence Colleague 1 told the panel that you had dispensed 1mg of Prucalopride (a laxative) instead of the 3mg Procholperazine (an anti-psychotic) which was prescribed to the patient. She explained the role of each medication and the implications for the patient had she not intervened.

This was supported by the contemporaneous note in the supervision record, dated 25 November 2016 and was signed by Colleague 1 and you, which states:

> '*Maggie had taken the drugs out to start dispensing and had dispensed PRUCALOPRIDE 1MG into a pot. I checked the drug and realised this drug was not on screen or due. The correct prescription was for PROCHOLPERAZINE 3MG. I asked Maggie what was in the pot and she pointed to the box on the trolley- the wrong drug and prescription. I asked her to look at it due to the error; she threw the wrong medicine in the bin. The correct drug was not in stock and needed to be ordered from pharmacy. This is a near miss.'*

Initially in your evidence you told the panel that you did not remember this. However, in cross-examination the following day you said that, having thought about it, this was a day on which you had taken your contact lenses out and you had been struggling to read the box. You demonstrated to the panel that you had been holding the box close to your face. You said that you were not going to dispense it but that you *"just couldn't read the box"*

without your contact lenses. You explained that you had pulled the medication out of the box to see if you could read it better. You said that Colleague 1 had been stood beside you and jumped in before you had a chance to say anything. You said that you had explained to Colleague 1 that you did not have your contact lenses, that you had taken them out because you were getting a headache and said that instead of accepting and recording what you had said, said *'we get this'* implying that Colleague 1 had behaved unprofessionally. You denied making this up. You said that you did not dispense it, that it never came out of the packet and reiterated that a lot of what you said to Colleague 1 was not recorded.

The panel preferred Colleague 1's evidence, which was supported by the contemporaneous supervision notes, to your account. The panel noted that the supervision notes were signed by you as well as Colleague 1 as a true reflection of that day's supervision. The panel was satisfied that you had put the Prucalopride into a pot and that you intended to give this to the patient. The panel noted that this could have had serious consequences for the patient.

The panel concluded, on the balance of probability, that on 25 November 2016 in relation to an unknown patient you dispensed 1mg of Prucalopride when the correct dose was 3mg Procholperazine.

Accordingly this charge is found proved.

Charge 17

17. On 25 November 2016 disposed of prucalopride in a bin when the correct procedure was to send it back to the pharmacist.

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 25 November 2016, Colleague 1's oral and written evidence as well as your evidence.

In her evidence Colleague 1 told the panel that after dispensing the wrong medication (detailed at charge 16) you had disposed of the medication in the bin. Colleague 1 told the panel that this was not the correct procedure and that all medication which was dispensed but not used should be sent back to the pharmacist for destroying.

This was supported by the contemporaneous note in the supervision record, dated 25 November 2016 and was signed by Colleague 1 and you, which states '*… I asked her to look at it due to the error; she threw the wrong medicine in the bin...'*

In your evidence you told the panel that you did not know that medication needed to go back to the pharmacist to be destroyed and that no one had told you this. You said you put it in the sharps bin as that was what everyone else did. You said you admitted that you had '*followed suit because I was a sheep'* and did what everyone else did which '*was stupid'*. You said that you were not trying to minimise what you had done but re-iterated that at that time you did not know the correct procedure was to send it back to the pharmacist. You told the panel that it was not Prucalopride as you denied ever dispensing this medication.

The panel has already found as a matter of fact that you dispensed Prucalopride as detailed at charge 16 above. The panel was satisfied, on the basis of Colleague 1's evidence (which was supported by a signed contemporaneous record) along with your admission that you would dispose of unused medication in the sharps bin, that it was more likely than not that on 25 November 2016 you disposed of Prucalopride in a bin when the correct procedure was to send it back to the pharmacist.

Accordingly this charge is found proved.

Charge 18

18. On 6 December 2016 did not include a water injection in a patients TTO.

This charge is found NOT proved.

In reaching this decision, the panel took into account the unsigned supervision notes dated 6 December 2016, as well as your evidence.

The contemporaneous note in the supervision record, dated 6 December 2016, states '*…Water for injection was missing from a TTO this had to be sent out to the patient discharge address'.* The panel noted that this record was not signed by you or your supervisor on that shift. Further the panel did not hear evidence from this supervisor.

In your evidence you told the panel that the TTO's were ready but when you checked the TTO's the pharmacy had not included water injections. You said that you had pointed this out to your supervisor and that you had put in some water injections from the ward stock but that you did not have enough and had to send the rest out in a taxi.

The panel concluded that the NMC had not discharged its duty of proof in respect of this charge. The only evidence to support it is an unsigned supervision note, the author of which (your supervisor on the shift) had not provided evidence to this panel. The panel considered there was no evidence that you were responsible for including the water injections with the TTO's and that a doctor would have needed to prescribe these and a pharmacist would issue them. Further the panel considered that you had provided a plausible explanation and that you had found some water injections on the ward to include with the TTO's.

Accordingly this charge is found NOT proved.

Charge 19

19. On 28 December 2016 did not carry out a syringe driver check which was due at 12.30pm

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 28 December 2016, Colleague 1's oral and written evidence as well as your evidence.

In her evidence Colleague 1 told the panel that you missed a syringe driver check on this shift. She said that after a syringe driver is set up it should be checked after 30 minutes and then every four hours to ensure it is working correctly. She said when she asked you why you had not completed the four hourly check you said you had forgotten.

This was supported by the contemporaneous note in the supervision record, dated 28 December 2016 and was signed by Colleague 1 and you, which states:

> '*Syringe driver check on a patient was missed - syringe driver in place for FastTrack patient for 24 hour pain relief, I asked Maggie what time was it checked she said she was just going to do it. When I assisted her with this the 12:30 pm check had been missed, Maggie said she forgot. Explained importance of 4 hourly check and accurate documentation*'.

In your evidence you said you did not remember this incident.

The panel accepted Colleague 1's evidence which was supported by the contemporaneous supervision document which was signed by her and you.

The panel therefore concluded that, on the balance of probabilities, on 28 December 2016 you did not carry out a syringe driver check which was due at 12.30pm.

Accordingly this charge is found proved.

Charge 20

20. On 13 January 2017 were unable to say what warfarin was used for

This charge is found NOT proved.

In reaching this decision, the panel took into account the signed supervision notes dated 13 January 2017, Colleague 1's oral and written evidence as well as your evidence.

The only mention of Warfarin in the signed supervision notes for 13 January 2017 was that Colleague 1 and you had discussed Warfarin dosing and how it is done and why.

When questioned regarding this charge Colleague 1 could not recall this.

In your evidence you said you did know what Warfarin was for but you could not remember if it was an anti-coagulant or anti-platelet. You said that Colleague 1 '*went into war and peace on the negatives and never once has she put in the logs what I said*'.

The panel was not satisfied from the documents before it that there was sufficient evidence to support this charge. The panel therefore concluded that the NMC had not discharged its burden of proof regarding this charge.

Accordingly this charge is found NOT proved.

Charge 21

21. On 13 January 2017 on going to administer a patient with cynacthen iv bolus did not clean the bung.

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 13 January 2017 as well as your evidence.

The panel had regard to the contemporaneous note in the supervision record, dated 13 January 2017 and was signed by Colleague 1 and you, which states:

> '*Maggie went to give a patient cynacthen Iv bolus, she took the alcohol swab to the bedside but forgot to clean the bung prior to administration. We discussed this at the time and Maggie said she forgot.'*

The panel also noted that the same issue is recorded in the supervision record from 21 November 2016 which states '*I have had to remind Maggie about cleaning bung prior to flushing cannulas…*'.

In your evidence you said you could not remember and that you did not know whether you did or did not clean the bung.

The panel considered that there was a clear contemporaneous record that was signed by Colleague 1 and you detailing that you had not cleaned the bung prior to going to administer IV medication.

The panel concluded, on the balance of probability, that on 13 January 2017 on going to administer a patient with cynacthen IV bolus you did not clean the bung.

Accordingly this charge is found proved.

Charge 22.1 and 22.2

22. On 13 February 2017 in relation to Patient K:

22.1. Did not assist the patient in sitting up.
22.2. left the patients lower half exposed.

These charges are found not proved.

In reaching this decision, the panel took into account the supervision record dated 13 February 2017 and your evidence.

The contemporaneous supervision record detailed an incident on 13 February 2017 in which it was stated that you did not assist a patient to sit up and that you left the patient's lower half exposed. However, the panel noted that the authors of the supervision record were not called to give evidence to the panel and there was therefore no opportunity to cross-examine or test this evidence. Further the record is not signed by either of the authors nor by you.

You denied leaving the patient uncovered.

The panel was not satisfied from the documents before it that there was sufficient evidence to support charges 22.1 and 22.2. The panel therefore concluded that the NMC had not discharged its burden of proof regarding this charge.

Accordingly charge 22.1 and 22.2 are found NOT proved.

Charge 22.3

22.3. when attending to the patient did not wear gloves and/or a gown.

This charge is found proved.

Under cross-examination you accepted this charge. You said you admitted that you did not have gloves and gown on but that this was because the patient was not in the side room for anything infectious.

The panel accepted your admission and therefore found this charge proved.

Whilst employed at Mallard Court:

Charge 23

23. On 26 July 2018 on checking Resident C's syringe driver at 3am and/or 5am did not recognise that it had been connected to the wrong port.

This charge is found proved.

In reaching this decision, the panel took into account the syringe driver form for Resident C on the relevant date, the minutes of an investigation meeting dated 1 August 2018 and the outcome letter dated 3 August 2018, Ms 7's oral and written evidence as well as your evidence.

In her evidence Ms 7 explained how a syringe driver worked and the implication for the resident of not receiving their medication. She confirmed that you were on shift that night and would have been responsible for checking the syringe driver. She said the syringe driver was set up at 22:15 on 25 July 2018 and was checked at 03:00 on 26 July 2018 when you re-sited the giving set, you also checked it at 05:00. When the syringe driver was checked by a nurse on the following shift at 08:00 she noted it was connected to the wrong port.

This was supported by the contemporaneous documentation. The syringe driver form shows you signed as having checked the syringe driver for the resident at 03:00 and 05:00 and that the nurse who checked it at 08:00 noted the connection was in the wrong port.

The panel noted that Ms 7 met with you to discuss this and had sight of the minutes of this meeting. It noted that you were suspended from administering medication on the basis of this incident.

In your evidence you said that you had not set up the syringe driver. You told the panel that the syringe driver kept alarming but that you thought this was because the resident had got up and 'dragged it about'. You said that from the advice you got you thought that both ports were open. Under cross-examination you admitted this charge, you said "*I put my hands up to that one, I didn't recognise it was connected to the wrong port."*

The panel considered Ms 7's oral evidence. It found that she was not entirely helpful. However, she did describe that there was a clear difference in the two ports on the syringe driver and confirmed that her written statement and supporting documents were true. The panel was satisfied that her written statement was made close to the incident and was supported by the written documentation. The panel therefore accepted Ms 7's evidence.

The panel concluded that, on the balance of probabilities, on 26 July 2018 on checking Resident C's syringe driver at 3am and/or 5am you did not recognise that it had been connected to the wrong port

Accordingly this charge is found proved.

<u>Whilst employed at Forest Hill:</u>

Charge 24

24. On 4 October 2018 did not apply a morphine patch to a patient who required one

This charge is found NOT proved.

In reaching this decision, the panel took into account the patient's MAR chart and the controlled drug record, Ms 8's and Ms 9's oral and written evidence as well as your evidence.

The panel noted the prescription patch being referred to was not a morphine patch but a 'BUTEC' seven-day patch. The panel heard evidence that this was an opioid painkiller in the same family as morphine.

Having had regard to the MAR chart, the panel noted that the BUTEC seven-day patch was not due until 5 October 2018, having previously been given on 28 September 2018.

When questioned during cross-examination and asked to check the MAR chart Ms 8 agreed that the patch would not have been due until 5 October 2018 which was when you had administered it to the patient.

In her evidence Ms 9 maintained that the patch should have been changed on 4 October 2018 but admitted, when questioned by the panel, that 5 October would have been 7 days after 28 September 2018.

The panel concluded that it was clear that a patch was not required by the patient on 4 October 2018 and even though you had admitted the charge during your evidence, you were in fact correct in not applying it until 5 October 2018.

Accordingly this charge is found NOT proved.

<u>Whilst employed at the Chesterfield Royal Hospital:</u>

Charge 25.1

25. On 28 December 2018:

25.1. did not initiate checking the patients wristbands.

This charge is found proved.

In reaching this decision, the panel took into account the Medicines Administration: Record of Competency Assessment dated 28 December 2018, the progress review and development plan dated 28 December 2018, Colleague 2's oral and written evidence as well as your evidence.

In her evidence Colleague 2 explained her role and the purpose of medications assessments. She told the panel that she had been asked to complete a medication assessment with you by the ward matron following concerns with regard to your practice. She told the panel that the wristbands were important to ensure patients are correctly identified when administering their medication especially as some patients may be disorientated or have cognitive impairment. She said that you did not initiate checking of the wristbands of patients during medication administration. In her oral evidence she said that when you realised that some patients did not have wristbands you should have addressed this and organised wristbands for them. She said it was not good enough to just get someone else to do this.

This was confirmed in the contemporaneous the Medicines Administration: Record of Competency Assessment dated 28 December 2018 which was signed by you and Colleague 2. In this it was recorded '*Basic 'Five Rights' of drug administration <u>not</u> utilised, 4/8 patients not wearing wristbands, only verbal check of DOB'.* It is further recorded that this was the reason that you had not passed this assessment.

The progress review and development plan dated 28 December 2018 and signed by Colleague 2 also confirms this. It states:

> '*I raised with Maggie that I could not see her utilising the policy in relation to the 'Five rights" of medications administration specifically around 'Right Patient'. Four*

of the [eight] allocated patients were not wearing a wristband which until this was pointed out to Maggie she was unaware of as she had not attempted checking of the wristband.'

In your evidence you said that you did not check the wristbands as the patients did not have any. You said you had a discussion with Colleague 2 about how to proceed if a patient did not have wristbands on. You said that four of the patients did not have wristbands on so how could you follow the policy? You said that you did not know how to use the wristband printer and that you would not touch it as it was always breaking. You said you would get the ward clerk to print them. You said that all of the patients were in nighties and their arms were all visible so you could tell they did not have wristbands. You said if you did not feel safe and did not know who a patient was you would not give medication. You said that if the right patient identifiers are not there then you would not risk giving mediation.

The panel noted your comment about not being able to check patient wristbands if they were not there. The panel considered that in your evidence you sought to blame others for the lack of wristbands rather than taking responsibility for this yourself. In the panel's view you ignored the fact that four out of the eight patients did have wristbands and Colleague 2 was clear that you did not initiate a check on any wristbands.

The panel accepted Colleague 2's evidence which it considered was clear, credible and corroborated by the contemporaneous and signed documentation.

The panel therefore concluded that, on the balance of probabilities, on 28 December 2018, you did not initiate checking the patient's wristbands.

Accordingly this charge is found proved.

Charge 25.2

25.2. On being informed that Patient B had a deficit had to be prompted by Colleague 2 to consider this when treating the patient.

This charge is found proved.

In reaching this decision, the panel took into account the Medicines Administration: Record of Competency Assessment dated 28 December 2018, the progress review and development plan dated 28 December 2018, Colleague 2's oral and written evidence as well as your evidence.

In her evidence Colleague 2 told the panel that during the course of the medication administration and her observation that a HCA approached you and told you that a patient had a deficit. She explained to the panel that this meant that the patient's blood pressure dropped significantly when they changed position from lying down to standing. She said she had to remind you that the HCA had reported the deficit and that she had to prompt you to consider it in light of the medications due to be administered. She said if she had not prompted you that she thought it likely that you would have administered Atenolol (which lowers blood pressure) and that given the deficit you should have checked with medical staff whether it was appropriate to administer the medication before doing so.

This was confirmed in the contemporaneous the Medicines Administration: Record of Competency Assessment dated 28 December 2018 which was signed by you and Colleague 2. In this it was recorded '*1x patient had significant postural deficit of 40mm/HG but would have given Atenolol if not prompted'.*

The progress review and development plan dated 28 December 2018 and signed by Colleague 2 also confirms this. It states: '*One of the HCAs informed Maggie that a patient had a deficit in her blood pressure on standing of approx 40mm/Hg resulting in a systolic bp of 64mm/Hg. On administering this patient's medications I prompted Maggie to think if it was appropriate to give the Atenolol without further review. On reflection Maggie felt that this should be discussed with the medical team first.'*

You denied this charge. In your evidence you told the panel that you did a manual blood pressure on this patient to check that the recording was accurate as the blood pressure machine could sometimes give an unreliable reading. On further questioning, the panel was not convinced you understood the significance of a patient having a blood pressure deficit as you seemed focused only on the accuracy of the recording tool and not in the variation between lying and standing blood pressure. You said that you had a discussion with Colleague 2 regarding omitting giving medication to this patient as it could be detrimental and that you would tell the doctor about it. You denied that Colleague 2 prompted you, maintaining that it was a discussion. You maintained that you did a manual blood pressure despite Colleague 2 not referring to this in her evidence or contemporaneous records of that medication round.

The panel considered that Colleague 2 was completely clear in her evidence that you would have given the medication to this patient had she not prompted you to consider the impact this may have. The panel accepted Colleague 2's evidence which was corroborated by contemporaneous signed records. The panel considered your denial of this charge was contradicted by the contemporaneous evidence which was signed by you. The panel therefore preferred Colleague 2's evidence.

The panel concluded that, on the balance of probabilities, on 28 December 2018, on being informed that Patient B had a deficit you had to be prompted by Colleague 2 to consider this when treating the patient.

Accordingly this charge is found proved.

Charge 26

26. On 10 January 2019 gave a patient rivaroxaban which was not theirs.

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 10's evidence and your evidence.

The panel noted Ms 10's evidence which appeared to contradict this charge. She stated *'There was no way of confirming what had been administered to the patient'.*

The panel was not satisfied that there was sufficient evidence to support this charge. The panel therefore concluded that the NMC had not discharged its burden of proof regarding this charge.

Accordingly this charge is found NOT proved.

Charge 27.1

27. On 18 January 2019:

    27.1. did not seek assistance in managing the airvo machine.

This charge is found NOT proved.

In reaching this decision, the panel took into account an email from Ms 12 dated 21 January 2019, Ms 12's oral and written evidence as well as your evidence.

In her evidence Ms 12 explained how an Airvo machine worked. She told the panel that when she had asked you about the Airvo settings you had made a flippant comment that the Airvo machine had been alarming all day and that you had no idea what was wrong with it. When she looked at the machine Ms 12 had identified what the problem was. She told the panel that, as far as she was aware, you had not sought assistance in managing the Airvo machine which you should have done if you were not familiar with it.

In her email dated 21 January 2019 she stated:

'… patient was on an Airvo 301 flow an (sic) 60% oxygen. Maggie didn't know what the Airvo was, how to manage it, check the settings, or manage the water for irrigation that had run out. Without the water for irrigation the patient is receiving extremely high levels of oxygen without any humidification. (3 other band 5 nurses on shift and a band 6 in charge) I have huge concerns that she is not asking for help with equipment she is not familiar with, or raising the same concerns to the nurse in charge.'

In your evidence you said that you did seek assistance. You admitted that you were not '*au fait*' with the Airvo machine and told the panel that you had asked for help with this. You questioned how Ms 12 would know whether you had asked anyone for assistance as she was coming onto the shift after you so she was not there throughout your shift.

The panel was of the view that Ms 12's evidence was credible however it noted that she was not present on the same shift as you rather she received the handover from you. The panel accepted that there was an issue with the Airvo machine when Ms 12 looked at in on handover however, the panel has seen no evidence to prove that you did not seek assistance with the Airvo machine as you have stated.

The panel was not satisfied that there was sufficient evidence to support this charge. The panel therefore concluded that the NMC had not discharged its burden of proof regarding this charge.

Accordingly this charge is found NOT proved.

Charge 27.2.1, 27.2.2 and 27.2.3

27.2. In relation to an unknown patient did not carry out the following tasks as requested to:

27.2.1. perform a full set of repeat bloods.

27.2.2. carry out an urgent ECG.

27.2.3. prepare the patient for an ECG.

These charges are found proved.

The panel considered these charges together.

In reaching this decision, the panel took into account an email from Ms 12 dated 21 January 2019, Ms 12's oral and written evidence as well as your evidence.

In her evidence Ms 12 told the panel that this patient had been complaining of chest pain and was unwell. She said that you had been asked by a doctor about an hour and a half before handover to perform a full set of repeat bloods on this patient as well as an urgent ECG. She said that neither the bloods nor the ECG had been done by the time you handed over to her. She said that you had been flippant when the doctor returned and asked why they had not been done. She said that arranging repeat bloods and an ECG would have been your responsibility as the patient's nurse.

In her email dated 21 January 2019 she stated:

> '*This patient was unwell. The doctor had been on the ward at approximately 18:00 and requested and (sic) urgent ECG and repeat set of bloods. The patient had a raised potassium alongside persistently high blood sugars. The doctor who had requested these, came back to check the ECG, and that the bloods had been sent as I was receiving hand over from Maggie. Maggie had done neither the ECG or asked any one of her colleagues to assist her and take the bloods. I found myself apologising to the doctor for something that was absolutely nothing to do with me and then carried out the requests as a matter of urgency at the start of my shift'*

In your evidence you told the panel that you were not qualified to take bloods from patients. You said that you had notified whoever had asked you to take bloods that you were not able to and you said you believed you had asked a colleague to take the bloods.

You said that you had explained to Ms 12 at handover that you had been unable to do this as you were not qualified to take bloods.

You told the panel that you had tried to do an ECG however you had not been able to because the ECG machine on the ward was broken. You said that you had tried to get a machine from the floor below but that they refused to lend you the machine, saying '*our equipment, our ward'*. You said that you had asked the HCA to go and ask for one from another floor but that they had refused to do this. You explained that the ECG department was closed as it closes at 18:00. You told the panel that you had explained all of this to the doctor and that he had said that it would have to wait for the ECG department to come and do one the next day. You said that you had also explained this to Ms 12.

You said that you had not prepared the patient for an ECG as you wanted to get the ECG machine first. You said you were not going to get her on the bed until you had the machine and could do the ECG.

The panel considered that there is clear evidence in the contemporaneous email that you did not perform a full set of repeat bloods when this had been requested of you. You have also admitted that you did not perform a full set of repeat bloods. The panel noted your explanation for this. You told the panel the doctor said he would *"put it down for the phlebs [phlebotomists] to do it tomorrow"*.

The panel considered that there is also clear evidence in the contemporaneous email that you did not perform an ECG or prepare the patient for an ECG when this had been requested of you. The panel noted your explanation for this which it did not consider credible. The panel considered that had it been the case that you could not get an ECG machine and the doctor had said it could wait until tomorrow Ms 12 would have mentioned this in her email. The panel noted that Ms 12 said that the doctor came back to check whether these had been done during your handover of the patient. The panel could not see why the doctor would have checked back if he had agreed with you that it could wait until tomorrow. The panel was concerned over your suggestion that a patient with chest

pain would have needed to wait until the next day for an ECG. The panel further noted that Ms 12 carried out the ECG and repeat bloods as a matter of urgency at the start of her shift. The panel concluded that Ms 12 must have been able to source an ECG machine to do this. It further noted Ms 12's evidence that any patient with chest pain should be transferred to a bed in preparation for an ECG in case their condition deteriorated and CPR was required.

In light of the above the panel preferred the evidence of Ms 12 which it considered to be clear and consistent with the contemporaneous email she sent. The panel considered her evidence to be credible and reliable regarding these charges. It considered that your evidence regarding the ECG machine was not plausible.

The panel therefore concluded that, on the balance of probabilities, on 18 January 2018, in relation to an unknown patient you did not perform a full set of repeat bloods, carry out an urgent ECG or prepare the patient for an ECG as requested to.

Accordingly charges 27.2.1, 27.2.2 and 27.2.3 are found proved.

Charge 27.3

27.3. Did not request assistance with one or more of the tasks listed at charges.
27.2.1 – 27.2.3

This charge is found NOT proved.

In reaching this decision, the panel took into account an email from Ms 12 dated 21 January 2019, Ms 12's oral and written evidence as well as your evidence.

In her evidence Ms 12 told the panel that she had spoken to the nursing sister who was in charge of your shift and who was distressed that you had not asked her for help.

In your evidence you said you did ask for help but that it was not forthcoming.

The panel was of the view that Ms 12's evidence was credible however it noted again that she was not present on the same shift as you, rather she received the handover from you. The panel has no evidence to prove that you did not seek assistance in the tasks listed at charges 27.2.1, 27.2.2 and 27.2.3.

The panel was not satisfied that there was sufficient evidence to support this charge. The panel therefore concluded that the NMC had not discharged its burden of proof regarding this charge.

Accordingly this charge is found NOT proved.

Charge 27.4

27.4. In relation to a patient who had bilateral leg ulcers did not dress her ulcers.

This charge is found NOT proved.

In reaching this decision, the panel took into account an email from Ms 12 dated 21 January 2019, Ms 12's oral and written evidence as well as your evidence.

In her evidence Ms 12 told the panel when she arrived on the ward that a patient was sat in a chair, her ulcers were not dressed but instead were on a towel on the floor which was wet. She said it was clear that her leg was infected, open and undressed. She said this could have resulted in further infection putting her at greater risk of harm. In addition the wet towel was leaking onto the floor which was a slip risk to the patient and staff.

In her email dated 21 January 2019 this incident is not mentioned.

In your evidence you said you had no recollection of this incident.

The panel was not satisfied that there was sufficient evidence to support this charge. There is no contemporaneous documentation relating to this incident and the panel was of the view that, had this occurred as alleged, Ms 12 would have recorded this in her email. The panel considered that Ms 12 may have mistaken this event with another in her recollection for the witness statement which was made eight months after the event. The panel therefore concluded that the NMC had not discharged its burden of proof regarding this charge.

Accordingly this charge is found NOT proved.

Charge 27.5

27.5. In relation to a patient who required IV fluids did not ask another member of staff who was competent to put IV fluids up to assist.

This charge is found NOT proved.

In reaching this decision, the panel took into account an email from Ms 12 dated 21 January 2019, Ms 12's oral and written evidence as well as your evidence.

In her evidence Ms 12 told the panel during her shift she noticed that IV fluids which had been prescribed at 18:00 had not been given to a patient. She then gave the IV fluids.

In her email dated 21 January 2019 she stated:

> '*IV fluids run out, new bag not put up. I am aware she is currently unable to do IV fluids and medications. However again there were plenty of other nurses available on that shift, that would have ensured the patient received the prescribed treatment.'*

In your evidence you said that the patient did not want the fluids up when they were prescribed as she had visitors, that these were ready and you had handed this over to Ms 12.

The panel was of the view that Ms 12's evidence was credible however it noted again that she was not present on the same shift as you, rather she received the handover from you. The panel has no evidence to prove that, in relation to a patient who required IV fluids, you did not ask another member of staff who was competent to put IV fluids up to assist. The panel was not satisfied that there was sufficient evidence to support this charge. The panel therefore concluded that the NMC had not discharged its burden of proof regarding this charge.

Accordingly this charge is found NOT proved.

Charge 27.6.1 and 27.6.2

27.6. Did not carry out one or more of the following tasks and/or did not delegate them:

27.6.1. reposition patients who were allocated to you.

27.6.2. carry out incontinence checks on patients that were allocated to you.

These charges are found proved.

The panel considered charge 27.6 as a whole.

In reaching this decision, the panel took into account an email from Ms 12 dated 21 January 2019, Ms 12's oral and written evidence as well as your evidence.

In her evidence Ms 12 told the panel that the majority of patients allocated to you were incontinent and were soaked through the incontinence pads to the bed. She told the panel

that when she went to assess the patients at the start of her shift one patient had been heavily incontinent in urine, which had soaked through to the bed sheets and subsequently dried. Another patient's bowels had opened and the faeces had dried onto the skin. She said that there had been no documentation relating to the patients being cleaned or changed during your shift. She said the patients had potentially been left for eight hours without receiving a reposition or incontinence check. She said incontinence checks should be performed, at a minimum, every four hours. This depends upon several factors, including the level of incontinence and patient skin integrity which could both warrant more frequent checks. She said that this was not solely your responsibility but that if you were too busy you should delegate this to an HCA to ensure that the checks are being done.

In her email dated 21 January 2019 she stated:‘

> *Finally in addition to these concerns, both myself and two HCA's who also reported to me that patients in bay 5 and the side rooms were found to be extremely wet, with continence products soaked through including the sheets in some cases. In addition one patient had their bowels open, evidently earlier in the day as the feaces (sic) had since dried onto the patients skin. The documentation shows that this patient hadn't been checked since approximately 1pm earlier that day. I appreciate this is not the SN sole responsibility but some ownership needs to be taken I feel, as she forms part of a team with her assigned HCA… we are under pressure at the moment… however I feel that when someone delivers care to this standard it reflects on us all. I work too hard for this to be the case.’*

In your evidence you said you could not answer this and that you could never find HCA’s on the ward. In cross-examination you said that the rule of thumb was to delegate this to the HCA’s. You said that the HCA’s would not work with you, that they went off and did their own thing, that they point blank refused to do what you asked and that the HCA’s dictated what they did on the ward. You said that you would not knowingly *“leave*

someone in a state". You agreed that the responsibility for this lay with you however you questioned how you could delegate something to someone you could not find.

The panel considered Ms 12's evidence to be compelling. She had clearly been affected by witnessing the lack of care provided to these patients. She was clear that it was the responsibility of the nurse to ensure that checks had been done and that the charts had not been filled out during your shift. The panel accepted Ms 12's evidence which was supported by her contemporaneous email.

The panel concluded that, on the balance of probabilities, on 18 January 2018 you did not reposition or carry out incontinence checks on patients who were allocated to you and/or did not delegate this.

Accordingly charges 27.6.1 and 27.6.2 are found proved.

Whilst employed at Blyth Country House:

Charge 28.1

28. On 15 April 2019 in relation to Resident E:
    28.1. did not sign the patients MAR chart at the time of administering her oromorph.

This charge is found proved.

In reaching this decision, the panel took into account the letter to you from Ms 13 dated 15 April 2019, an email from you to Ms 13 dated 16 April 2019, the controlled drug book and MAR chart for Resident E, Ms 13's witness evidence and your evidence.

In her evidence Ms 13 told the panel that you had not signed the MAR chart when you administered Oromorph to Resident E on 15 April 2019. She explained that this had come to light in a drug audit and it had been discovered that you had signed the controlled drug

book for administration of Oromorph to Resident E but that you had omitted to sign the MAR chart.

Ms 13 confirmed that the letter to you from her dated 15 April 2019 was misdated and should have been dated 16 April 2019. Ms 13 wrote to you to advise that it had been noticed that you had given Oromorph to Patient E at 21:40 and 00:05 but that this had not been recorded on the MAR chart.

In your response email to Ms 13, dated 16 April 2019, you admitted that you did not sign the MAR chart.

You did not provide evidence in relation to this charge. You concentrated on charges 28.2, 28.3 and charge 35.

The panel concluded that, on the balance of probabilities, on 15 April 2019, in relation to Resident E, you did not sign the patients MAR chart at the time of administering her Oromorph.

Accordingly this charge is found proved.

Charge 28.2

28.2. administered oromorph at 21.40pm and 00.05am which was before the prescribed time frame which was 4-6 hours.

This charge is found proved.

In reaching this decision, the panel took into account the controlled drug book for Resident E, the letter to you from Ms 13 dated 15 April 2019, 281 Ms 13's witness evidence and your evidence.

In her evidence Ms 13 said that you had administered Morphine Sulfate (Oromorph) at 21:40 and 00:05 which was within three hours. She told the panel that the prescription had been amended on 9 April 2019 to a higher dose but at the same frequency rate of every four to six hours. This was corroborated by Ms 13's letter to you.

The panel had regard to Patient E's prescription which details '*5mls every 4-6 hrs max 30mls in 24 hrs*' and is dated 9 April 2019. The controlled drug book shows that you signed for administration of Oromorph at 21:40 and 00:05 on this shift.

You admitted this. You said that you were concerned the patient was in pain as she had not had a pain patch for two days, so you gave Oromorph again sooner than prescribed.

Based on the evidence before it the panel concluded that, on the balance of probabilities, on a shift starting on 15 April 2019, in relation to Resident E, you administered Oromorph at 21:40 and 00:05 which was before the prescribed time frame of four to six hours.

Accordingly this charge is found proved.

Charge 28.3

28.3. ignored Colleague 3's instruction in relation to the frequency of oromorph to be administered.

This charge is found proved.

In reaching this decision, the panel took into account Colleague 3's local statement regarding this incident, Colleague 3's witness evidence and your evidence.

In her evidence Colleague 3 said that during a morning handover, on a date she did not recall, you approached her to say that you wanted to give Patient E more Oromorph. She said that she did not think this was allowed but that she would check with the Macmillan

Nurse. The Macmillan Nurse confirmed that Oromorph could not be given more frequently than prescribed, which was once every four to six hours however she said that she could increase the dose from 2.5mg to 5mg. She made this clear on Patient E's file and prescription that the dose could be increased to 5mg but that the frequency remained the same at four to six hours. Colleague 3 said that she had handed this over to you when you started your shift that evening.

Colleague 3 told the panel that the following morning you had said that you had given Patient E another dose of Oromorph after two and a half hours despite her clear handover the night before. Colleague 3 said that she told you that you could not administer Oromorph to Patient E more frequently than four hours. She said that your response was something like '*Oh well she has had it and she is not dead yet'*. She said this had shocked both her and the HCA's who were present at the time.

This was corroborated by Colleague 3's local statement which was signed by her. She states:

> '*During handover - Maggie pointed to the MAR chart and stated that the Oromorph was 'now 1-2 hourly'. I pointed out that the prescription was 4-6 hourly but the dose had increased - and that [the Macmillan Nurse] had confirmed that it would not be more frequent because it is not protocol in the community (I pointed to the prescription and showed Maggie it was 4-6 hourly). Maggie's response was 'Oh well, she had 2 x doses in 2 hours the night before, but it hasn't killed her*'.

Ms 13 told the panel that she had been concerned that despite strong instruction to the contrary you would continue to make medication errors. She thought that you posed a danger to the residents and decided to terminate your employment.

You denied this charge. You said Colleague 3 did not tell you this until the next morning.

The panel was satisfied that Colleague 3 had a conversation with you about Patient E's prescription of Oromorph. The prescription was changed before this date and the panel accepted that this had been explained to you. The panel considered it was clear on the prescription that the dose was only to be given every four hours at a minimum.

The panel concluded that, on the balance of probabilities, on 15 April 2019, in relation to Resident E, you ignored Colleague 3's instruction in relation to the frequency of Oromorph to be administered.

Accordingly this charge is found proved.

Charge 29

29. On 10 October 2016 were unprofessional during handover in that you were rolling your eyes and/or sighing.

This charge is found proved.

In reaching this decision, the panel took into account the signed supervision notes dated 10 October 2016, Colleague 1's oral and written evidence as well as your evidence.

In her evidence to the panel Colleague 1 said when she was providing a handover on 10 October 2016 that you were rolling your eyes and sighing which was very unprofessional behaviour.

This was corroborated in the supervision record for 10 October 2016 which was signed by Colleague 1 and you, which states:

> *'Hand over - Maggie rolled eyes and sighed when handing over with myself to night staff. I asked Maggie what was the matter and she said nothing. I didn't question*

this again in front of the night staff as I wanted to speak to Maggie privately about professional conduct and why there was a problem.'

In your evidence you initially said that you could not answer this and that you did not know if you had done this or not. You said that at this time you felt that no matter what you did it was wrong in eyes of Colleague 1. In cross-examination the following day you said you could not remember if you did or not. You agreed that if you did then it was unprofessional. You said that Colleague 1 had jumped in in the middle of a handover and that you had found her to be quite rude. You said if you did roll your eyes you would apologise but that you did not agree that you had. You said Colleague 1 jumped in to say what she wanted to say but that she could have waited. You then said that there was a distinct possibility that you had rolled your eyes and sighed.

The panel was of the view that registered nurses have an obligation to work alongside fellow professionals in a constructive and respectful manner. The panel considered that sighing and rolling eyes would be seen as disrespectful to the person speaking and did not consider this to be conduct that would be expected of a registered nurse. The panel noted that Colleague 1 was upset enough by this behaviour that she recorded it in that day's supervision notes. They also noted that there was clearly friction between you and Colleague 1. Colleague 1 told the panel in her oral evidence that you were not happy being supervised but that it was her role to try and support you and your practice.

The panel accepted Colleague 1's evidence, which was supported by the contemporaneous supervision notes. The panel noted that the supervision notes were signed by you as well as Colleague 1 as a true reflection of that day's supervision. The panel also noted that, whilst you deny this charge, you did admit that there was a distinct possibility that you had acted in the way described and you admitted that this kind of behaviour would be unprofessional.

In light of the above the panel concluded that, on the balance of probabilities, on 10 October 2016 you were unprofessional during handover in that you were rolling your eyes and/or sighing.

Accordingly this charge is found proved.

Charge 30

30. On or around 9 October 2018 were unprofessional during an investigation meeting.
This charge is found proved.

In reaching this decision, the panel took into account Ms 8's oral and written evidence as well as your evidence.

In her evidence to the panel Ms 8 said that she had been asked to conduct an investigation meeting with you, in her capacity as Clinical Lead, regarding some medication errors. Ms 8 said as she worked on a different unit she could be impartial in the investigation meeting given she had not worked with you.

Ms 8 described your behaviour during the meeting as dismissive and that you did not seem bothered about the errors she was bringing up. She said you became quite aggressive and that your responses were abrupt, mainly '*don't remember, don't know'*. She said that you remained hostile and dismissive throughout the interview. She said that when she showed you documents you would slam your finger into them on the table and say things like '*well yeah I missed it'* and that you did not appear to be bothered. She said at the end of the meeting you just said that you were going and walked off. She remembered wondering if you spoke to other people how you had spoken to her during the meeting.

In her oral evidence to the panel Ms 8 said '*I would have expected more professionalism. I felt a bit taken aback. If it were me, I would have been mortified and apologetic, but there wasn't any of that. Just 'I don't remember', and shrugged shoulders'*.

The panel considered Ms 8 to be a professional, credible witness. She had a clear recollection of the events that day.

In your oral evidence under cross-examination you said *"[There's a] distinct possibility I was unprofessional. I wasn't thinking straight as there was a level of stress in my head and a nurse I'd never met was interviewing me"*. You said that you apologised if you made her (Ms 8) feel uncomfortable but you felt just as uncomfortable. You said that you did not feel that you were rude to her, you think it was more frustration on your part. You denied slamming your fingers down, but accepted that you did point at things on the MAR. You said that you put in a complaint about the Clinical Lead (not Ms 8) and that you got suspended a day later with "*no rhyme or reason"*. You said if you did make Ms 8 feel the way described then that was wrong of you but at the time your head was not in the game.

The panel considered that the behaviours described by Ms 8 in the investigation meeting were not professional and were not the standards expected of a registered nurse. A registered nurse is expected to cooperate with any investigation by their employers. You were described as hostile, aggressive and dismissive to someone investigating medication errors you were alleged to have made. The panel considered that this kind of behaviour was certainly unprofessional.

In light of the above, the panel concluded that, on the balance of probabilities, on or around 9 October 2018 you were unprofessional during an investigation meeting.

Accordingly this charge is found proved.

Charge 31

31. On 8 June 2017 were unprofessional in that you threw a tube of sando K tablets at the wall in Bay 2.

This charge is found proved.

In reaching this decision, the panel took into account the file note of a meeting between you and Ms 14 on 11 June 2017, Ms 14's and Ms 16's witness evidence and your evidence.

The panel recognised that you found discussing this charge upsetting.

In her evidence Ms 16 said that on 8 June 2017 you threw a tube of Sando K at the wall in a bay of patients out of frustration. This incident took place when she was also on duty. She did not directly witness this, however after the incident she spoke with you in the clinical room and you informed her of what had happened. She said you were upset and frustrated.

In her evidence Ms 14 said that Ms 16 had informed her of an incident where you had been witnessed to throw a tube of Sando K tablets at the wall in Bay 2 in frustration after losing your temper. She said that you had admitted this and that it was wrong.

This was corroborated by the contemporaneous file note of a meeting between you and Ms 14 on 11 June 2017 to discuss the incident on 8 June 2017. This was signed by Ms 14 and you. This states:

> *'[a patient] had started hurling abuse at Maggie, saying she was 'a crap nurse' 'wasn't fir (sic) to be a nurse' and that he did not want to be cared for by her… Maggie responded calmly with 'that's fine' and that she would ask somebody else to respond to his needs. She then walked away to empty bed space in the bay and threw the tube of sando K at the wall…*'

In your evidence you admitted that you threw a tube of Sando K tablets at the wall in Bay 2. You explained to the panel that this was in frustration and anger regarding a comment from a patient. You said the patient had said something to you relating to your private life which had hurt and upset you. When you walked out of the bay the Sando k tablets were still in your hand and you just chucked them.

In cross-examination you admitted that you should not have done this and agreed that it was unprofessional. You said that on reflection you were kicking yourself for doing it but that the patient had pushed your buttons.

The panel considered that this was unprofessional behaviour. Throwing a tube of tablets at a wall was an aggressive action against a patient who made a derogatory comment. The panel noted that this would have been witnessed not only by that patient but by anyone else in the bay including staff, other patients and their relatives, who may have been alarmed at witnessing this. The panel noted that patients can, at times, say horrible things but as a registered nurse you have to recognise that patients are vulnerable and in a position of dependence. You must remain objective and prioritise their needs. The panel considered that acting in such an aggressive manner in front of patients was completely inexcusable and outrageous behaviour for a registered nurse. You demonstrated no understanding of the impact of this behaviour. The panel noted that you continued to excuse your behaviour stating that what the patient said to you was horrible. The panel had no reason to doubt that this was the case however it considered that a registered nurse should never act in such a manner.

The panel concluded that, on the balance of probabilities, on 8 June 2017 you were unprofessional in that you threw a tube of Sando K tablets at the wall in Bay 2

Accordingly this charge is found proved.

Charge 32

32. In September 2018 were rude and/or abrupt to Resident B's sister.

This charge is found proved.

In reaching this decision, the panel took into account Relative B's and Colleague 4's witness evidence as well as your evidence.

Relative B's recollection of what you said was not clear. She said that she could not remember the words you used. However she had been left with an impression of someone rude, hostile and abrupt. She remembered feeling like you had no empathy and that she had been disappointed and thought your behaviour was not appropriate or professional. She raised her concerns with Colleague 4.

Colleague 4 told the panel that Relative B had approached her to raise her concerns about your behaviour. She said that Relative B had reported you to be abrupt and rude in front of Resident B. Colleague 4 told the panel that Resident B and her family required a lot of sensitivity and care due to Resident B's diagnosis of dementia when she was quite young. In her oral evidence Colleague 4 said that when she raised this with you she had been taken aback by your behaviour and described you as difficult and aggressive. She said that your attitude was confrontational and not particularly kind. She said that she felt you did not take it seriously and lacked reflection. She said it appeared that you did not care about their residents.

You said that you did not agree that your behaviour had been unprofessional to Relative B. You said that you apologised if you made her feel that way or that you upset her. You said you were not rude or abrupt but that you had tried to explain to Relative B that you did not know where the rest of Resident B's notes were. You said you were trying to explain to her that you could not force Resident B to eat or drink. You described to the panel that you often had to '*shove a sandwich in [Resident B's] hand when she was walking up and down the corridor just to get her to eat'*. The panel considered this description demonstrated a lack of empathy.

Under cross-examination you said you did not know why Relative B would make this up but that you think with hindsight Relative B could not recall the incident herself. You said Relative B had not looked visibly upset at the time.

The panel noted your apology to Relative B but noted that this was a qualified apology. The panel considered that you had demonstrated an inability to put yourself in Relative B's position. It considered your description of shoving sandwiches at residents to get them to eat demonstrated little care on your part.

The panel accepted Relative B's and Colleague 4's evidence. It considered that their accounts were corroborated by the other. Colleague 4 had a very clear recollection of the events which had obviously impacted on her. The panel considered that she was a clear and candid witness and that her evidence in respect of this charge was both credible and reliable. It considered that you appeared to be oblivious to the impact your actions had on Relative B and on Colleague 4.

The panel concluded that, on the balance of probabilities, in September 2018 you were rude and/or abrupt to Resident B's sister.

Accordingly this charge is found proved.

Charge 33

33. On an unspecified date between 24 October 2018 and 6 November 2018 when speaking to Colleague 4 were unprofessional in that you said words to the effect of 'Fuck this, I am giving you my notice'.

This charge is found proved.

In reaching this decision, the panel took into account Colleague 4's witness evidence and your evidence.

Colleague 4 told the panel that you had approached her for more information around the disciplinary meeting. She said that she had sent you a letter giving you notice of the hearing on 24 October 2018 and the hearing was due to be held on 6 November 2018. Colleague 4 said that she told you that she could not discuss anything with you before the hearing so as not to compromise the disciplinary process. She said that you then swore at her saying *"Fuck this"* and verbally handed in your notice. She said that she had needed to let you out of the building and explained that she would have to send you a resign in haste letter explaining that the disciplinary hearing would continue despite your resignation. In her oral evidence Colleague 4 told the panel how taken aback she had been by your behaviour, she said that she had tried to remain professional and not to speak about the matter prior to the hearing.

You told the panel that you did not say this. You said that your actual words had been *"Fuck this. [PRIVATE]".* You said that you recognised that you should not have said this but you did. [PRIVATE].

In cross-examination you said that you accepted that the words you used were unprofessional and you said that you had apologised to Colleague 4. You said that the problem was that "*sometimes I open my gob".*

The panel preferred Colleague 4's evidence which was consistent over your evidence which varied over the two days you gave evidence.

The panel considered that it did not matter what words had followed you saying '*Fuck this'*. In the panel's view swearing at anyone in a professional environment would be considered unprofessional. The panel noted that you had been angry but considered that this did not excuse your behaviour and that you would have known the standards expected of a registered nurse.

The panel concluded that, on the balance of probabilities, on an unspecified date between 24 October 2018 and 6 November 2018 when speaking to Colleague 4 you were unprofessional in that you said words to the effect of '*Fuck this, I am giving you my notice'*.

Accordingly this charge is found proved.

Charge 34.1 and 34.2

34. On an unknown date whilst working for Chesterfield Royal Hospital were unprofessional in that you:
    34.1. challenged the staff nurses who were transferring a patient by saying words to the effect of "why are you transferring this patient? You have loads of empty beds."
    34.2. Said the words set out in charge 34.1 in front of the patient.

This charge is found proved.

The panel considered this charge as a whole.

In reaching this decision, the panel took into account Ms 12's evidence and your evidence.

In her evidence Ms 12 said that when she worked alongside you on a night shift during which staff nurses turned up to transfer a patient to your ward you said to them '*why are you transferring this patient? You have loads of empty bed*s'. She said that she was embarrassed by you asking this and that it was an awful thing for a patient to hear as they are in a strange place and can be frightened. She said that it was the role of a nurse to accept patients, not to challenge the transfer of patients onto the ward unless it would put other patients at risk. She told the panel that this patient did not pose any such risk and that there was space on the ward for them. She told the panel that she had been surprised that you had challenged the staff transferring the patient and that your manner had been

confrontational. The panel considered Ms 12's recollection of this incident to be very clear, it was obviously an incident which had impacted on her.

You told the panel in your evidence that you had not meant to offend by challenging the staff who were moving the patient. You said that you were surprised by it as it was about 02:00 and the rule of thumb with dementia patients was not to transfer them at night as it caused more problems. You said that the patient was not awake or alert enough to understand what you had said.

In cross-examination you accepted that you had challenged the patient transfer. You said that you did not know why you had done so and that you thought you had "*engaged gob before brain on that one"*. You said that it wasn't in the context that Ms 12 portrayed it. You said that she never spoken to you about it afterwards and if she had been shocked and surprised she had not said anything to you. You admitted that the patient had been present when you challenged the transfer but that you believed they were asleep, were semi coherent or had dementia.

The panel noted your various explanations that the patient was asleep, semi-conscious and had dementia. In the panel's view, if any of these had been the case, it was no excuse to speak like that in front of a patient. If the patient had been asleep or dozing, they could quite easily have woken during this incident and even if the patient had dementia and could not understand the words you used, they could have understood the tone used which Ms 12 had said was confrontational. The panel considered that this would have been a horrible thing for the patient to overhear, they would not have felt wanted, welcome or safe.

The panel considered that it would have been highly unprofessional to challenge the transfer of a patient from another ward in these circumstances.

The panel preferred Ms 12's evidence to your evidence. She was consistent and the panel found her account credible and reliable. Whilst you accepted that you had challenged the

patient transfer and that you had done so in front of the patient the panel considered that you failed to see that this had been unprofessional. It noted that in your evidence you accepted that you said words to this effect but that you had said it in a jokey way.

The panel concluded that, on the balance of probabilities, that whilst working for Chesterfield Royal Hospital you were unprofessional in that you challenged the staff nurses who were transferring a patient by saying words to the effect of "*why are you transferring this patient? You have loads of empty beds*" and that you said this in front of the patient.

Accordingly charge 34.1 and 34.2 are found proved.

Charge 35

35. On 16 April 2019 were unprofessional in that when speaking about the incident at charge 28.2 said words to the effect of "oh well she has had it and she is not dead yet."

This charge is found proved.

In reaching this decision, the panel took into account Colleague 3's local statement, Colleague 3's evidence and your evidence.

The panel reminded itself of Colleague 3's evidence detailed at charge 28.2 above. She said that your response was something like '*Oh well she has had it and she is not dead yet*'. She said this had shocked the HCA's who were present at the time.

In Colleague 3's statement which was signed by her. She states: '*…Maggie's response was 'Oh well, she had 2 x doses in 2 hours the night before, but it hasn't killed her*'.

The panel noted that you laughed and shook your head during Colleague 3 giving evidence to the panel on this charge.

In your evidence you said that you did not say those words. You said that you did say that you had given it to the patient already but that you did not say that she was not dead yet. You said that when the incident at 28.2 was pointed out to you that you were '*kicking'* yourself and that you '*felt a complete and utter plonker'*.

You said that whilst you did not have any issues with Colleague 3 you had flagged up some issues in the care home. You said that you could not comment on Colleague 3's motive for saying you said this. You said that it was possible that you had been unprofessional but that you knew you had not said those words.

The panel noted that this was the incident that had alerted Colleague 3 and Ms 13 to a potential problem with your practice and attitude.

The panel preferred Colleague 3's evidence to yours. The panel considered that Colleague 3 was a credible witness who had a clear recollection of an incident which had obviously had an impact on her. She was clear that you had said this at a handover with other people present and that herself and the HCA's had been shocked by the comment. She said that it had felt a very cold and unprofessional thing for you to say.

The panel concluded that, on the balance of probabilities, on 16 April 2019 were unprofessional in that when speaking about the incident at charge 28.2 you said words to the effect of "*oh well she has had it and she is not dead yet*."

Accordingly this charge is found proved.

Charge 36

36. On 28 January 2019 when applying for a job at Blyth House put Barchester Healthcare as your present or most recent job when you knew that your present most recent employer was Chesterfield Royal Hospital.

This charge is found proved.

In reaching this decision, the panel took into account the application form for Blyth House completed by you and dated 28 January 2019, Ms 13's evidence and your evidence.

The panel could see from the application form for Blyth House completed by you and dated 28 January 2019 that you had listed Barchester Healthcare as your most recent employer and had not listed Chesterfield Royal Hospital at all.

Ms 13 confirmed this was the application form you submitted for the job at Blyth House.

You said that whilst you accepted you did not put Chesterfield Royal Hospital on the application form that you had told Ms 13 during the interview and had asked her if you should add it to the form then. You said Ms 13 had said not to bother. You said that you had just forgotten to put it on the form.

The panel concluded that, on the balance of probabilities, on 28 January 2019 when applying for a job at Blyth House you put Barchester Healthcare in the form as your present or most recent job when you knew that your present most recent employer was Chesterfield Royal Hospital.

Accordingly this charge is found proved.

Charge 37

37. Your actions at charge 36 were dishonest in that at the time of making the application you sought to conceal that your present, most recent employer was Chesterfield Royal Hospital.

This charge is found NOT proved.

In reaching this decision, the panel took into account the application form for Blyth House completed by you and dated 28 January 2019, Ms 13's evidence and your evidence.

In its consideration of this dishonesty charge the panel accepted the advice of the legal assessor that the test to be applied is that set out at paragraph 74 in the case of *Ivey*.

You told the panel that it had not been your intention to be dishonest in putting Barchester as your most recent employer rather than Chesterfield Royal Hospital. You said that you had simply forgotten when filling in the form but mentioned at interview that you had made a mistake. Your evidence was that you were told it was not necessary to amend the form. You said that if you had been seeking to conceal your employment at Chesterfield Royal Hospital you would not have taken your DBS check from there to the interview at Blyth House.

The panel noted that Ms 13 had not provided, in her witness statement or live evidence any material to suggest you were dishonest. Ms 13 had a poor recollection of what was said at the interview, although she took interview notes they were not before the panel. However, she did remember you disclosing that you were under investigation by the NMC.

The panel considered that you have provided an explanation as to why you put down Barchester Healthcare as your most recent employer and the NMC has not been able to disprove your explanation. The panel was not provided with evidence to persuade it that your omission was anything other than accidental.

For the reasons set out above the panel considered that the NMC has not discharged the burden of proof in relation to this charge. The panel therefore decided that there is no basis for making a finding of dishonesty.

Accordingly this charge is found NOT proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to a lack of competence in respect of the charges found proved between 1 – 28 or misconduct in respect of the charges found proved between 29 – 37.

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.

After handing down the determination on facts the hearing reconvened the following morning (7 September 2021).

You advised the panel that you would not be able to supply it with essential documents you wished it to consider in respect of your current fitness to practise as you were at work. Although you had prepared reflective statements, they were on a removable memory stick which had gone missing from your work desk. The material was also available on your home computer but you would only be able to send it to the panel secretary in the evening.

The panel considered that, in light of this issue, it would be preferable to consider issues of lack of competence/misconduct separately and prior to determining the issue of current impairment.

The panel accepted the advice of the legal assessor. It noted that whilst Rule 24(12) envisaged the whole impairment stage being heard together the preamble to the Rule permitted the panel to depart from the stages set out in the Rules.

To make the best use of the available time, whilst allowing you the opportunity to provide documentation, the panel determined to hear submissions on lack of competence and misconduct only and to make a decision on lack of competence and misconduct before hearing submissions relating to impairment. Only if the panel decides if the facts found proved amount to a lack of competence or to misconduct, will it move on to consider whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence and/or misconduct.

Submissions on lack of competence

Ms Stevenson invited the panel to take the view that the facts found proved between charges 1 and 28 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)*' in making its decision in regard to charges 1 – 26 and the updated version of the *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2018)*' in regard to charges 27 – 28. The panel noted that this new version of the Code is substantially similar to the 2015 version, but it has been updated to reflect the regulation of nursing associates as well as nurses and midwives. This being the case the panel will refer to 'the Code' on the understanding that the version being referred to relates to the charges as detailed above. When identifying any breaches of the Code the panel will make it clear if anything mentioned is not reflected in both the 2015 Code and the updated Code.

Ms Stevenson referred to her written submissions in which she identified the specific, relevant standards where the NMC contended that your actions amounted to a lack of competence.

Ms Stevenson submitted that the competency concerns occurred over three years, within different work places and environments, and were raised by more than one colleague. She

submitted that these concerns were serious breaches. First of all, due to the repetitive nature of the concerns, occurring over a long period of time. Secondly, because some of the concerns occurred despite being placed on capability plans and/or programmes and with mentoring, advice, guidance and/or assistance from colleagues. Thirdly, because you have not observed the basic tenets of the nursing profession but instead followed an unsafe level of practice. She submitted that patients were placed at a serious risk of harm by your actions and/or omissions.

Ms Stevenson submitted that the facts found proved show that your competence at the time was below the standard expected of a registered nurse.

You submitted that the facts found proved did not amount to a lack of competence, but rather to a lack of knowledge. You told the panel that you still do not know what some of the charges were about so you are unable to say if they happened or not. You said that it was not that you are not remorseful, if you did something you will admit it, but how can you admit something if you do not know what you have done. You took the panel to several of the charges and provided explanation either for your actions/omissions or said that you did not know what a particular charge was about. You said you were not trying to blame anyone else.

Submissions on misconduct

As misconduct is not defined in the Rules, Ms Stevenson invited the panel to have regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Stevenson invited the panel to take the view that the facts found proved between charges 29 and 37 amount to misconduct. She identified the specific, relevant standards where the NMC contends that your actions amounted to misconduct.

Ms Stevenson submitted that the misconduct concerns again occurred over a period of three years, within different work places and involving different complainants, both colleagues and a family member of a resident. The NMC submits that these concerns are serious breaches. First of all, because attitudinal concerns are live and present. Secondly, because colleagues and/or members of the public should be able to have trust in you and depend on your professionalism and have open communication with, and feel respected by you. Additionally, such behaviour is not 'role model behaviour' for students and newly qualified nurses and midwives to aspire to. Thirdly, because you have not observed the basic tenets of the nursing profession.

Ms Stevenson submitted that your actions and/or omissions as proven fall far short of what would be expected of a Registered Nurse. Colleagues would expect that they could rely upon their other colleagues to work together as a team, be dependable and respectful, communicate effectively and deliver safe and effective care. The public would expect the profession to be dependable and properly care for friends, relatives and members of the public. They would expect nurses to uphold a competent and professional reputation. She therefore invited the panel to find misconduct.

You told the panel that you accepted that you should not have thrown the Sando K and that you did not do this because you were angry, rather it was because you were upset. You said '*yes granted they [patients] say things and we should be more professional'*. You said you did not agree that it was an aggressive action. You said that it was not just a derogatory comment from the patient that prompted your action, it was '*quite an offensive comment'*. You highlighted to the panel some of the findings on the charges with which you disagreed.

The panel accepted the advice of the legal assessor. He referred to the cases of *R (Calhaem) v GMC* [2007] EWHC 2606 (Admin) and *Krippendorf v GMC* [2001] 1 WLR 1054 in respect of lack of competence. In respect of misconduct, the legal assessor

referred to the cases of *Roylance; Mallon v GMC* [2007] SC 426 and *Doughty v GDC* [1988] AC 164.

Decision and reasons on lack of competence

In reaching its decision the panel accepted the definition of 'deficient professional performance' in the case of *Calhaem* as being synonymous with lack of competence:

> *'…a standard of performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by a fair sample of the (registrants) work.'*

The panel considered each of the remaining charges individually to assess whether it amounted to a lack of competence.

Charge 1.1

1. In or around June 2016 whilst working for Doncaster and Bassetlaw Hospital
    1.1. On becoming aware of Patient F's low urine output did not take any action.

In relation to charge 1.1, the panel considered this to be serious. The panel noted that you had been qualified for over a year and were not new to the ward at this stage. The panel noted that Ms 14 had considered this to be a lack of competence. The panel was of the view that it was alarming that a nurse of your experience would not have acted appropriately in this situation. It considered that this charge did amount to a lack of competence.

Charge 1.2

1.2. Were unable to manage a patient who was on sliding scale insulin.

In relation to charge 1.2, the panel considered there was insufficient evidence that you should have been able to manage a sliding scale insulin at the time of this incident. It noted that everyone has to learn these skills at some point. The panel therefore considered that this charge did NOT amount to a lack of competence.

Charge 1.3

1.3. Did not seek assistance and/or accept assistance regarding your inability to manage the patient who was on sliding scale insulin.

In relation to charge 1.3, the panel considered that not seeking assistance if you do not know how to do something was serious and had significant implications for any patient in your care. The panel noted that you had admitted you did not know how to manage the sliding scale. The panel considered that you did not recognise or raise the fact that you needed assistance and determined that this amounted to a lack of competence.

Charge 1.4

1.4. Were unable to recognise the significance of a patient having haematemesis.

In relation to charge 1.4, the panel would expect a nurse to understand the potential serious implications where a patient was vomiting blood. The panel noted that the site manager, Ms 6, was so alarmed by your performance as a nurse that she reported this to Ms 14 as well as attending to the patient herself. This was reflected in the contemporaneous records. The panel considered that this was serious and significant and amounted to a lack of competence.

Charge 2.1

2. On an unknown date whilst working for Doncaster and Bassetlaw Hospital in relation to a patient whose airways were occluding:

2.1. did not press the emergency buzzer.

In relation to charge 2.1, the panel noted the circumstances described by Ms 14 who told the panel that sometimes newly qualified nurses freeze in these types of situation. As the incident occurred on a date unknown, the panel considered that this may have been the first time you were in a situation such as this. The panel considered this did NOT this amount to a lack of competence.

Charge 4.3

4. On 22 July 2016 on being informed that Patient H was experiencing a hypoglycaemic episode:

4.1. Did not provide immediate assistance.

In relation to charge 4.1, the panel considered that this was a serious situation, noting that a hypoglycaemic episode can be life-threatening. It noted that this happened on a ward which specialised in caring for patients with diabetes, Ms 15, had to tell you to go to the patient. In addition another nurse (Ms 16) was already concerned enough to be on her way to assist. The panel noted that the other nurses involved in this incident had been very concerned that you had not picked up on the seriousness of the patient's condition. The panel considered that this amounted to a lack of competence.

Charge 4.3

4.3. Were unaware of what the medication glucagon was for.

In relation to charge 4.3, the panel noted that you had been working on a ward which specialised in caring for patients with diabetes for some time. Ms 15 confirmed that there were regular lectures in caring for patients with diabetes. The panel considered that not knowing what Glucagon was for in these circumstances amounted to a lack of competence.

Charge 4.4

4.4. Incorrectly prioritised the patient's foot dressing over the patient's hypoglycaemic episode.

In relation to charge 4.4, the panel considered that it was inappropriate to prioritise a foot dressing when a patient was having a hypoglycaemic episode. The panel considered that this indicated that you did not understand the seriousness of the patient's condition. It considered that this clearly indicated a lack of competence.

Charge 7

7. On 10 October 2016 on conducting a handover did not provide the full details of one patients care plan.

In relation to charge 7, the panel accepted that Colleague 1 had said that there was no error on your part. The panel noted that you did not know the full details and therefore could not be expected to have communicated these. The panel considered that this did NOT amount to a lack of competence.

Charge 8

8. On 11 October 2016 in relation to a patient who was unwell with chest pain

8.3 did not inform the nurse in charge

In relation to charge 8.3, the panel reminded itself of your evidence and its findings in relation to charge 8. You said that you had sought medical attention for this patient. The panel considered that, in the circumstances described, whilst it would have been desirable to alert the nurse in charge, it did NOT amount to a lack of competence not to have done so.

Charge 10

10. On 4 November 2016 on being aware that a patient should receive a reading ten minutes after treatment is provided stated to Colleague 1 words to the effect of "in 10 minutes but I'm not going to do it then because it won't have had the chance to go up as yet."

In relation to charge 10, the panel considered that you had failed to grasp the importance of testing every 10 minutes even if the levels did not change much in that time. The panel considered that a nurse would be expected to follow policy and procedure, particularly a recently qualified nurse who was on a capability programme. The panel noted that you had to be prompted to follow this policy because you considered that you knew better. The panel considered that your deliberate failure to follow policy amounted to a lack of competence and indicated an attitudinal deficit.

Charge 11

11. On 21 November 2016 did not complete 15 minute observations on a patient who had had a blood transfusion.

In relation to charge 11, the panel noted that blood transfusions carry a high risk and the policy on 15 minute observations is in place for a reason which is to ensure that patients are closely observed. The panel noted that you had been reminded by Ms 14 of the importance of the 15 minute observations and the policy in respect of the previous transfusion. Your explanation for not conducting the observations on the patient was that you did not have time. The panel noted that you had been qualified for some time when this incident occurred and if you did not have the time you should have delegated this clinical task. The panel considered that you displayed a lack of understanding of the importance of conducting these observations and the risk to the patient. The panel considered that this was serious, significant and amounted to a lack of competence.

Charge 12

12. On 24 November 2016 in relation to an unknown patient dispensed 20mg of omeprazole when the correct dose was 40mg.

In relation to charge 12, the panel considered that this was a drug error and a single mistake. It considered that this was not so serious as to amount to a lack of competence.

Charges 13.1 and 13.2

13. On 24 November 2016 in relation to an unknown patient:

13.1. Did not recommence IV KCL.

13.2. Did not seek assistance to recommence IV KCL.

In relation to charge 13.1, the panel noted that it was essential that this patient received this medication as soon as possible, any delay in receiving the medication could have put the patient at a risk of harm. The panel considered that if you were not trained on reconnecting IV KCL (intravenous potassium chloride) then the fact that you did not do this could not amount to a lack of competence. However, in relation to charge 13.2, the panel considered that, if you were not trained, then you had a responsibility to seek assistance and ensure that the patient received the prescribed medication. The panel considered that it was clear from the supervision records made at the time of the events that you did not accept or seek support. The panel considered that this amounted to a lack of competence.

Charges 14.1 and 14.2

14. On 24 November 2016 when drawing up flushes and water for injections:

14.1. Did not clean the sterile water vials.

14.2. did not clean the glass water bottles.

In relation to charges 14.1 and 14.2, the panel was of the view that these were basic, fundamental errors in IV therapy. The panel was clear that you had completed your IV training and ought to have been aware of the potential for harm if infection control policies were not adhered to. The panel noted your response was *'well nobody else bothers so why should I?'*. The panel considered that your failure to follow policy and disregard for, or lack of understanding of, the importance of safe clinical practice amounted to a lack of competence in respect of charges 14.1 and 14.2, and indicated attitudinal issues in following policy.

Charge 15

15. On 25 November 2016 did not use IVAB labelling.

In relation to charge 15 the panel considered that it is vitally important that IV AB's (intravenous antibiotics) are labelled as this allows anyone attending the patient to see what has been given, by who and when. This would be particularly important if a patient were to have a reaction to the medication. The panel noted that you had already had the importance of labelling IV AB explained to you that day. In the panel's view you either did not retain this information or chose to disregard it. In any event the panel considered this serious and to amount to a lack of competence.

Charge 16

16. On 25 November 2016 in relation to an unknown patient dispensed 1mg of prucalopride when the correct dose was 3mg procholperazine.

In relation to charge 16 the panel was seriously concerned with your explanation that you had taken out your contact lenses and were struggling to see the medication you were administering. The panel considered that you did not understand the importance of stepping back if you were not fit to conduct a drugs round and that this would amount to a lack of competence, particularly in light of the previous medication competency issues that had been identified by your employer. In any event the panel was satisfied that the charge found proved amounted to a lack of competence.

Charge 17

17. On 25 November 2016 disposed of prucalopride in a bin when the correct procedure was to send it back to the pharmacist.

In relation to charge 17 the panel did not consider this to be sufficiently serious as to amount to a lack of competence.

Charge 19

19. On 28 December 2016 did not carry out a syringe driver check which was due at 12.30pm

In relation to charge 19 the panel concluded that this was a simple error, it had no evidence as to when the next check took place. The panel determined that this would not amount to a lack of competence.

Charge 21

21. On 13 January 2017 on going to administer a patient with cynacthen iv bolus did not clean the bung.

In relation to charge 21, the panel noted that by the time of this incident you had been qualified for over two years and you still did not clean the intravenous additive bung despite having completed your intravenous therapy training, having had the importance of this explained to you and being under supervised practice. The panel considered that this demonstrated a lack of improvement. It determined that this amounted to a lack of competence.

Charge 22.3

22. On 13 February 2017 in relation to Patient K:

22.3. when attending to the patient did not wear gloves and/or a gown.

In relation to charge 22.3 the panel considered that there was not sufficient information to understand the full circumstances of this incident. Although you had admitted this charge the panel noted that it had not heard evidence from any staff who had witnessed this. The panel concluded that this did not amount to a lack of competence.

Charge 23

23. On 26 July 2018 on checking Resident C's syringe driver at 3am and/or 5am did not recognise that it had been connected to the wrong port.

In relation to charge 23 the panel considered that you had been qualified for three years by the time this incident occurred. It noted that the syringe driver had been alarming, it should have been obvious that the patient was not receiving the medication, and there is

no evidence that you sought assistance. The panel considered that you should have investigated why it was not working, recognised that you needed external help and escalated this. The panel considered that this demonstrated a lack of competence.

Charge 25.1

25. On 28 December 2018:

25.1. did not initiate checking the patients wristbands.

In relation to charge 25.1 the panel considered that giving medication is a fundamental part of a nurses role, and to give medication a nurse is required to fulfil the '*five rights'* which include '*right person'*. The panel noted that the policy was clear that wristbands should be always be checked. This is especially relevant in an environment where elderly patients can be confused, to ensure you have the right person before administering treatment. The panel noted that you had been qualified three and a half years by this point and were being supervised on medication rounds because of concerns from Ms 10 in regards to your clinical competence. The panel considered that this did amount to a lack of competence.

Charge 25.2

25.2. On being informed that Patient B had a deficit had to be prompted by Colleague 2 to consider this when treating the patient.

In relation to charge 25.2 the panel considered there was a clear failure to understand what a deficit is in your explanation of what occurred. The panel was concerned that you still do not appear to understand that a deficit is the difference between blood pressure when lying and standing, as opposed to simply low blood pressure. The panel noted that you required to be prompted to consider the implications of giving the medication to a patient in these circumstances. The panel considered that this did amount to a lack of competence.

Charge 27.2.1

27. On 18 January 2019:

27.2.1 In relation to an unknown patient did not carry out the following tasks as requested to:

In relation to charge 27.2.1 the panel noted your assertion that you were not trained in venepuncture. It therefore considered that this was not a lack of competence.

Charge 27.2.2

27.2.2. carry out an urgent ECG.

In relation to charge 27.2.2 the panel considered your explanation to have been implausible. It noted that Ms 12 was able to perform an ECG on this patient after the shift handover. The panel considered that you had failed to appreciate the seriousness of this patient experiencing chest pain and the doctor's instruction to do an urgent ECG. The panel consider that this did amount to a lack of competence.

Charge 27.2.3

27.2.3. prepare the patient for an ECG.

In relation to charge 27.2.3 the panel considered that it was fundamental, basic care for a patient with chest pain who was on a ward to be transferred to a bed to ensure that, should their condition deteriorate, they were in a position where emergency care could be administered. The panel noted that you had been qualified for almost four years and had been working on medical wards for two years at the time of this incident. The panel considered that this did amount to a lack of competence.

Charge 27.6.1 and 27.6.2

27.6. Did not carry out one or more of the following tasks and/or did not delegate them:

27.6.1. reposition patients who were allocated to you.

27.6.2. carry out incontinence checks on patients that were allocated to you.

In relation to charges 27.6.1 and 27.6.2 the panel considered that you had neglected the basic fundamental care of these patients. You had a duty to ensure these patients were clean and cared for. This is essential to maintain patients' skin integrity, dignity and for infection control purposes. The panel considered this to have been a serious and significant lack of competence to not attend to the needs of these patients.

Charge 28.1

28. On 15 April 2019 in relation to Resident E:

28.1. did not sign the patients MAR chart at the time of administering her oromorph.

In relation to charge 28.1 the panel considered that administering medications, particularly controlled drugs, requires a registered nurse to be vigilant. The panel considered that as part of the responsibilities of administering controlled drugs you need to adhere to signing the MAR chart, and that not doing so presented a serious risk to the patient. In looking at the circumstances of this incident as a whole, the panel considered there to be a pattern of a lack of gravity and concern when dealing with potent controlled drugs and a lack of adherence to protocol and policy which your training would have made clear. The panel considered that this amounted to a lack of competence.

Charge 28.2

28.2. administered oromorph at 21.40pm and 00.05am which was before the prescribed time frame which was 4-6 hours.

In relation to charge 28.2 the panel considered that it was a clear lack of competence to administer a drug in direct contravention of the prescription. It noted that the prescription should be checked every time a medication is administered in order to prevent such errors occurring.

Charge 28.3

28.3. ignored Colleague 3's instruction in relation to the frequency of oromorph to be administered.

In relation to charge 28.3 the panel noted that you had been prompted and you had decided to use your own judgement rather than follow instructions. It considered that you had been dismissive of the situation and appeared to lack an understanding of the seriousness of your actions. The panel considered that this was another example of your failure to follow policy and procedures which amounted to a lack of competence.

The panel next had regard to the terms of the Code 2015. In particular, the following standards:

1 Treat people as individuals and uphold their dignity

- 1.1 treat people with kindness, respect and compassion
- 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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

- 3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

8 Work cooperatively

- 8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
- 8.2 maintain effective communication with colleagues
- 8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff
- 8.4 work with colleagues to evaluate the quality of your work and that of the team
- 8.5 work with colleagues to preserve the safety of those receiving care

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

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

13 Recognise and work within the limits of your competence

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

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

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

16 Act without delay if you believe that there is a risk to patient safety or public protection

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

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

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

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

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard. The panel has concluded that charges 1.1, 1.3, 1.4, 4.1, 4.3, 4.4, 10, 11, 13.2, 14.1, 14.2, 15, 16, 21, 23, 25.1, 25.2, 27.2.2, 27.2.3, 27.6.1, 27.6.2, 28.1, 28.2, 28.3 individually amount to a lack of competence.

Taking into account the reasons given by the panel for the findings of the facts and lack of competence, 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 was unacceptably low and demonstrated a lack of competence.

Decision and reasons on misconduct

The panel moved to consider charges 29 – 36 and whether the facts found proved amounted to misconduct (noting that charge 37 was found not proved). When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. The panel noted that all of the misconduct charges with the exception of charge 35 and 36 were under the terms of '*The Code: Professional standards of practice and behaviour for nurses and midwives (2015)*'. Charges 35 and 36 related to '*The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2018)*'. The panel again noted that this new version of the Code is substantially similar to the 2015 version, but it has been updated to reflect the regulation of

nursing associates as well as nurses and midwives. This being the case the panel will refer to ‘the Code’ on the understanding that the version being referred to relates to the charges as detailed above. When identifying any breaches of the Code the panel will make it clear if anything mentioned is not reflected in both the 2015 Code and the updated Code.

The panel was of the view that your actions in respect of the misconduct charges 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 Treat people as individuals and uphold their dignity
  1.1 treat people with kindness, respect and compassion
  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

3 Make sure that people’s physical, social and psychological needs are assessed and responded to
  3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

8 Work cooperatively
  8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
  8.2 maintain effective communication with colleagues
  8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff
  8.4 work with colleagues to evaluate the quality of your work and that of the team
  8.5 work with colleagues to preserve the safety of those receiving care

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

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

13 Recognise and work within the limits of your competence

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

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

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

16 Act without delay if you believe that there is a risk to patient safety or public protection

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

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

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have

enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It considered each of the charges individually to determine whether the breaches of the Code identified amounted to misconduct.

Charge 29

29. On 10 October 2016 were unprofessional during handover in that you were rolling your eyes and/or sighing.

In relation to charge 29 the panel considered that this behaviour occurred in the context of a handover with colleagues and was directed towards a senior nurse who was tasked with supporting and assisting you. The panel considered that this behaviour was unprofessional. It noted that Colleague 1 had been so obviously upset by this behaviour that she had spoken to you about it and recorded it in the supervision notes of that day.

The panel considered that it demonstrated a lack of respect and a lack of understanding in how your behaviour impacts other people. It noted that this was undermining behaviour towards your mentor, which happened in a public area and could have been witnessed by staff, visitors and patients. The panel considered that, when set in context, this behaviour was serious and fell significantly short of what would be expected of a registered nurse. The panel considered it a highly unprofessional way to treat a member of your team. It considered that this did amount to misconduct.

Charge 30

30. On or around 9 October 2018 were unprofessional during an investigation meeting.

In relation to charge 30 the panel noted that Ms 8 had been shocked by your behaviour. You were described as hostile, aggressive, confrontational, rude and unprofessional. The panel noted that, whilst Ms 8 was a colleague, she had not worked with you and did not know you. The panel considered the description of your behaviour in the investigatory meeting and the way you made Ms 8 feel to have been highly unprofessional. The panel considered it demonstrated a lack of respect for colleagues, team work and the importance of investigating when mistakes have been made and accepting responsibility for your actions. The panel considered that this behaviour fell significantly short of that expected of a registered nurse and that it amounted to misconduct.

Charge 31

31. On 8 June 2017 were unprofessional in that you threw a tube of sando K tablets at the wall in Bay 2.

In relation to charge 31 the panel considered this to be behaviour which was highly inappropriate for a nurse in a ward of patients. It considered that you still appeared to have little understanding of the gravity of this incident, noting that you continued to excuse this behaviour in your submissions on misconduct. The panel considered that no matter how offensive you find a patient's comments, a registered nurse must acknowledge that patients are in a vulnerable position and are reliant on nurses for their care. The panel

considered that your actions that day, and your evidence to the panel, demonstrated a lack of understanding about how your actions impact on patients and colleagues. You did not acknowledge or appear to appreciate how your actions would have been viewed by anyone who witnessed this. The panel considered this to be a serious and significant falling short of the standards expected of a registered nurse. The panel considered this to amount to misconduct.

Charge 32

32. In September 2018 were rude and/or abrupt to Resident B's sister.

In relation to charge 32 the panel considered your behaviour to have been unprofessional and inappropriate. The panel noted that your behaviour had obviously deeply affected Relative B. The panel considered your qualified apology to Relative B at the hearing, in itself, was insulting. The panel considered that you had demonstrated a lack of empathy towards Relative B and Resident B. The panel considered that you lack understanding on how your behaviour impacted on others. It considered that your behaviour in respect of this charge fell significantly short of that expected of a registered nurse and amounted to misconduct.

Charge 33

33. On an unspecified date between 24 October 2018 and 6 November 2018 when speaking to Colleague 4 were unprofessional in that you said words to the effect of 'Fuck this, I am giving you my notice'.

In relation to charge 33 you admitted to saying '*Fuck this'* but continued to dispute the remainder of the charge in your submissions on misconduct. The panel considered that you have not appreciated that the swearing at another nurse is the part of the charge which is deemed unprofessional. The panel considered that swearing at another nurse, particularly one in a senior position as the Home Manager, demonstrated a lack of respect and was wholly inappropriate. The panel noted the impact this had on Colleague 4 and her response had been that she was ashamed to be on the same register as you. The panel

considered that your language was inappropriate for any nurse in a professional setting and that it fell significantly short of the standards expected. The panel considered that this charge did amount to misconduct.

Charge 34.1

34. On an unknown date whilst working for Chesterfield Royal Hospital were unprofessional in that you: 34.1. challenged the staff nurses who were transferring a patient by saying words to the effect of “why are you transferring this patient? You have loads of empty beds.”

In relation to charge 34.1 the panel considered the context of this charge. You were new to the ward and did not know the staff transferring the patient. Ms 12 told the panel that she was shocked at the disrespectful and confrontational manner in which you had addressed the staff transferring the patient. The panel considered that this was not cooperative and was a serious departure from the expected standards of collaborative working. The panel considered that it was not your role to challenge the transfer of a patient, particularly when there was a senior nurse, Ms 12, present who would have reviewed the appropriateness of the transfer if necessary. The panel considered that it was a highly unprofessional way to speak to colleagues. It considered that this did amount to misconduct.

Charge 34.2

34.2. Said the words set out in charge 34.1 in front of the patient.

In relation to charge 34.2 the panel considered to have challenged a transfer in front of a patient was serious and demonstrated a lack of compassion and kindness. The panel considered that your actions in respect of this charge to have fallen significantly short of those expected of a registered nurse and did amount to misconduct.

Charge 35

35. On 16 April 2019 were unprofessional in that when speaking about the incident at charge 28.2 said words to the effect of “oh well she has had it and she is not dead yet.”

In relation to charge 35 the panel considered that this demonstrated a lack of compassion for the patient. The contemporaneous record detailed that this was said in front of a senior nurse and other staff who were shocked. The panel considered that this charge demonstrated a lack of empathy and that rather than accepting you had made a mistake you sought to diminish its seriousness. The panel considered that this was a significant falling short of the standards expected of a registered nurse which, in the panel’s view, amounted to misconduct.

Charge 36

36. On 28 January 2019 when applying for a job at Blyth House put Barchester Healthcare as your present or most recent job when you knew that your present most recent employer was Chesterfield Royal Hospital.

In relation to charge 36 the panel considered there was no evidence that this was a deliberate act or anything other than a mistake. The panel did not consider that this amounted to misconduct.

The panel found that your actions at charges 29, 30, 31, 32, 33, 34.1, 34.2 and 35, both individually and collectively, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Submissions on impairment

Ms Stevenson provided written submissions 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. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Stevenson submitted that your fitness to practise is currently impaired. She submitted that the concerns identified are repeated, occurring over three years and in different workplaces, and related to both competency concerns as well as unprofessionalism and misconduct concerns. She submitted that a number of the competency concerns occurred despite you being on capability plans and being mentored or supervised by colleagues.

Ms Stevenson submitted that the unprofessionalism and misconduct concerns found proved, and the reoccurrence of these concerns in different workplaces, show evidence of live attitudinal concerns. She reminded the panel that you had been described as hostile, aggressive and dismissive. She highlighted that you had sought to blame others and had given unreliable, confusing and/or evasive evidence as well as a failure to demonstrate an understanding of the impact of your behaviour.

Ms Stevenson submitted that your actions and omissions had placed patients at a serious risk of harm. She submitted, in light of the panel's findings and the repeated attitudinal concerns, you have in the past and are liable in the future to act so as to put patients at unwarranted risk of harm.

Ms Stevenson submitted that your behaviour as found proved plainly brings the profession into disrepute, demonstrating an unsatisfactory level of care and an unsatisfactory way to

communicate with colleagues, which raises attitudinal concerns. She said that all of the charges found proved are deeply concerning.

Ms Stevenson submitted that you had plainly breached fundamental tenets of the profession.

Ms Stevenson invited the panel to consider whether your conduct is capable of remediation, whether it has been remediated, and whether your actions are likely to be repeated in future. She submitted that you have provided certificates and references which may indicate you have made improvements to your clinical practice.

Ms Stevenson submitted there are still concerns around your attitude. She submitted that there is limited evidence of insight, acceptance or remorse and as such there was a risk of repetition of the kind of behaviour found proved.

Ms Stevenson invited the panel to find that your fitness to practise is currently impaired.

You provided evidence under affirmation to the panel.

You said that at this moment in time that you are not currently impaired when you are working at Woodlands.

You spoke about improvements you felt you have made to policy and procedure at Woodlands with particular reference to measures relating to controlled drugs. You said you have a good rapport with the staff, you remember to say please and thank you to them and to speak to them how you would like to be spoken to. You said you have made mistakes and that you recognise these. You said that you do not go out of your way to upset people and said that you were in defence mode. You said you had apologised and you are remorseful.

You explained the support you have in place if you need assistance with clinical matters. Although you are the deputy manager and clinical lead/senior nurse of Woodlands, you said you have a good support network consisting of the nurses you work with at Woodlands, as well as the community matron.

You told the panel that you had done a reflective piece but that you could not access this to send to the panel as the memory stick it was saved on had gone missing and the laptop it was saved on was dead. You discovered the memory stick on the floor under your desk on a break between your evidence and calling your witness. However, you did not send the reflective piece to the panel to consider despite being reminded that it was open to you to do so.

You explained to the panel the difficulties and challenges you had faced working in and managing Woodlands during the Covid-19 pandemic. You said that the challenges had led you to undertake advanced training on verification of death. You told the panel about the training you have undertaken as well as the support which was available to help you cope with the after effects of working through the pandemic. You were highly emotional during the provision of this evidence and it was clear to the panel that you had found the experiences understandably traumatic. You told the panel that two thirds of the home's residents had succumbed to Covid.

Under panel questioning you told the panel what you have learnt from going through this process. You said you have learnt from your mistakes and learnt your lesson as you definitely did not want to be sitting before a panel again. You said that there were probably a lot of things you were doing differently as a result such as "*engaging [your] brain before mouth"* and that you recognised you should not have sworn at colleagues because it was rude. You said on reflection it was wrong to have rolled your eyes and that you would strive not to do that in future. You said that if a patient says something hurtful now, you know to walk away. However, you continued to attempt to justify your actions in throwing the Sando K.

You explained how incident reporting is done at Woodlands and the provisions that are in place for formal clinical supervision, although you admitted that this had not taken place in several months which was a concern for you.

You said that you have learnt that you want to stay working in the community and that an acute setting is not your strong point. You said you would like to be a Community Matron in future although for the immediate future you hope to stay at Woodlands and continue to work there with the new owners as the ownership is changing (on 10 September 2021).

You called Ms 17, the CEO of the group which currently runs Woodlands, to provide evidence as to your current impairment. Although Ms 17 has worked in the care sector for 36 years, she is not a registered nurse. She spends four to five days a week at Woodlands and assists with providing care for the residents whilst on site.

Ms 17 told the panel that there had been no clinical concerns raised about you and she had no concerns about your professionalism. She said you have a good relationship with the staff and ensure they are well cared for. She said you made sure that they always had lots of treats and snacks. She said she has never known you to be sharp, rather you are straightforward and that you will tell staff what needs to be done and how to get there. She said you will raise things with superiors or outside agencies if you are unable to deal with them.

Ms 17 told the panel she was aware of the NMC proceedings in relation to you. Ms 17 told the panel that the line manager who had been liaising with the NMC had left the company and did not hand anything over to her. She said that whilst she did not know the detail of the charges she knew that there had been issues regarding missing signatures on MAR charts, personal care records and issues with your attitude at work. She said she was not aware of what charges had been found proved.

Ms 17 said that you were initially employed as a nurse, then as a senior carer, you then had supervised shifts as a nurse until the interim conditions of practice were lifted. You

were then promoted to Clinical Lead and became Deputy Manager when the Home Manager left. She stated that the company did not feel that you were ready to step into the Home Manager role. She said that Woodlands, the staff and herself would have struggled without you. She said that the CQC inspection in February 2021 had found that Woodlands was still rated as *'requires improvement'*. This was in relation to infection control and issues with auditing. She told the panel that Woodlands is being transferred to new ownership tomorrow (10 September 2021).

Whilst the panel accepted that Ms 17 had extensive experience in the sector and that she has worked alongside you and had no concerns about your practice, it considered her evidence was only reliable to a point. It noted that she was not a registered nurse and so was not able to satisfy the panel in terms of whether you have remediated fully the concerns identified. In addition she did not appear to be concerned or curious about the charges that you faced or that were found proved. It found her evidence to be of limited assistance.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Grant, Cohen and Nicholas-Pillai v General Medical Council* [2009] EWHC 1048 (Admin).

Decision and reasons on impairment

The panel next went on to decide if, as a result of the lack of competence and misconduct, 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 be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In paragraph 76 of *Grant*, 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 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) *…*

In regard to the limbs of the test set out in *Grant*, the panel considered that the first three limbs were engaged in this case. The panel found that patients were put at risk of harm as a result of your lack of competence and misconduct. The panel noted that, in relation to some of the charges found proved the only reason patients did not come to harm was because your practice was being supervised.

The panel considered that your lack of competence and your misconduct had brought the profession into disrepute. The concerns regarding your lack of competence continued over several years and with different employers despite training and supervision. The panel found, when considering your competence, that you appeared unwilling or unable to comply with policies and procedures even after these had been explained to you. In

respect of your misconduct the panel concluded that the unprofessional behaviour as detailed in its previous findings clearly brought the profession into disrepute.

The panel considered its findings in relation to the charges found proved as well as its observations regarding the lack of competence demonstrated and your misconduct. It reminded itself of the themes identified and the lack of care and empathy demonstrated in your actions and behaviours as detailed. It considered that these actions breached the fundamental tenets of the profession.

The panel went on to consider whether you were liable to act in a way to put residents or patients at unwarranted risk of harm, to bring the profession into disrepute or to breach fundamental tenets of the profession in the future. In doing so, the panel assessed your levels of remediation, insight and remorse.

Regarding insight, the panel considered that you started to develop your insight during the course of this hearing. However the panel considered that your insight is limited and is still at the very early stages. The panel considered that, in your responses to panel questions, you were able to say what you might do differently in future and detailed what you had learned from the NMC proceedings, albeit that your answers were somewhat generic. You have started to reflect on your lack of competence and acknowledged that you had made mistakes. You were able to give some full examples of how you have developed your clinical practice around some of the charges found proved. You also acknowledged that some of your behaviour which led to the misconduct charges had been unprofessional and that you had been wrong to act that way. However, the panel considered that your (undated) reflective statement, received before the commencement of this hearing, was egocentric and self-serving, in that you sought to shift the blame for your poor performance onto others rather than taking accountability for your own shortcomings. Throughout these proceedings you have continued to deflect responsibility and blame others. The panel did not receive a further reflective piece from you in relation to its findings of fact despite allowing you time to provide this. Taking all of this into account the panel considered that your insight is limited.

In turning to consider remediation of the concerns, the panel considered the questions identified in the case of *Cohen*. Is the conduct remediable? Has it been remedied? Is it highly unlikely to be repeated?

The panel noted that the facts amounting to lack of competence related to clinical failings that, although in numerous clinical areas and over a significant period of time, were, in the panel's view, fundamentally capable of remediation. The panel observed that the misconduct charges found proved were more difficult to remediate and suggested attitudinal issues which were prevalent over a significant period of time. However, the panel considered that these concerns could potentially be remediated by the development and demonstration of appropriate insight into the circumstances of what had occurred, empathy for those who witnessed the misconduct, and an understanding of how to develop coping mechanisms to prevent the events from recurring in future.

Having determined that the charges found proved were objectively capable of remediation, the panel considered whether you had in fact remediated the shortcomings in your competence and conduct as identified by the panel. The panel determined that it had heard insufficient evidence to persuade it that you had remediated the concerns identified.

In relation to the lack of competence concerns, the panel acknowledged that you had, in your oral testimony today, provided evidence to the panel that you now understood the significance of some of the clinical failings found proved and would behave differently in future circumstances. The panel considered that the evidence given by Ms 17, and the references from colleagues that you have supplied, indicate that no concerns about your clinical performance have been raised since you commenced employment with your current employer in September 2019, and that you have made progress in clinical competence terms. The panel further acknowledged the numerous training certificates you had provided. It noted that much of this was mandatory training although there were some advanced certificates such as the verification of death training. However, it noted that it had received no documentary evidence of successful medication assessments, or

progress under any supervised practice in recent years, that would satisfy it that all of the concerns found proved had been fully addressed and remediated. The panel further noted that you have continued to contend that you do not understand some of the lack of competence charges found proved, despite the panel having clearly set out the evidence upon which it reached the relevant conclusions. On this basis, the panel is not satisfied that you have remediated the concerns found proved regarding your lack of competence.

As you were working as the sole registered nurse on shift, provided no references or evidence of your performance from any supervising registered nurse and appeared to be relying on the external NHS Community Matron for whatever supervision you had, the panel was of the view that it had not been provided with a reliable assessment of your current clinical performance.

In respect of the misconduct concerns, the panel acknowledged your statements that you are now trying to remember to think before speaking, and to think about how you present yourself to people. The panel was reassured by your assurance that you now say “please” and “thank you” to your colleagues and that you endeavour to speak to them as you would like to be spoken to. The panel also acknowledged the evidence of Ms 17 that she had never had, or heard from others about, any concerns regarding your professionalism. However, the panel considered that the reflective statement submitted by you, and the evidence that it heard from you during proceedings, showed a continuing failure to understand the impact of your behaviour upon others, and a desire to attribute blame to others for creating the circumstances that led to the incidences of misconduct found proved. For example you continued to seek to excuse and provide justification for your behaviour in throwing a tube of Sando K by telling the panel that another patient on the ward had chastised the patient who had made the offensive comment to you and had remarked to you that [the patient who made the comment] had been out of line. Only when pushed by the panel did you consider how the patients may have felt witnessing that behaviour saying they may think “*oh my God, if that’s who we having looking after us, we’d rather be at home*”. The panel was of the view that you still do not understand the

gravity of your actions nor the impact on patients, their families, your colleagues or the reputation of the profession.

The panel noted there has been a continued theme in regard to your actions and behaviours going back as far as 2016 with the same descriptions of you recurring with different employers. Ms 14 described you as having a poor attitude and being aggressive and abrupt. Colleague 3 described your attitude as flippant. Colleague 4 said your behaviour made her feel ashamed to be on the same register as her (and apologised for having said this as, whilst it was true, it was unkind). Relative B found you rude and abrupt. Ms 13 described you as '*bolshy*', overconfident and to disregard procedure. Colleague 1 had many concerns over your unprofessional behaviour and spoke to you about this regularly. Ms 8 found you to be aggressive, hostile and dismissive.

Taken from the facts found proved the panel surmised that you have problems both with authority and processes and a disregard for procedures.

In an unsigned reference, dated 2019, from your current employment there is reference to your attitude and staff finding you 'sharp'. The panel acknowledged that there have been no concerns raised by colleagues regarding your attitude since then. It accepted that Ms 17 said she had no concerns and the Area Manager (Mr 18) provided a written reference (undated) in which he said he was pleased with your manner.

The panel accepted the advice of the legal assessor in reference to the case of *Pillai*, in which it was determined that the attitude of the [registrant] during proceedings can be taken into account at the stages of impairment and misconduct. The panel considered that your behaviour during the course of these regulatory proceedings has not exhibited the level of professionalism that it would be reasonable to expect from a registered nurse in these circumstances. The panel accepted that you were under the impression that the hearing would be tailored to suit your work requirements. However, the panel noted the following examples of your behaviour:

a. Whilst noting that you are not represented and the challenges that this can present, you failed to prepare for the proceedings adequately, to have the appropriate documentation available to you, and to have read it before the start of the hearing; your disorganisation caused delay. Despite clear invitations from the panel to read carefully the parts of the determination available to you, you appeared not to have done so by the time you came to give evidence regarding lack of competence, misconduct and impairment and instead did so whilst giving evidence;
b. You have behaved discourteously towards the witnesses giving evidence in these proceedings, including on occasions rolling your eyes, shaking your head and laughing during their evidence, which was observed in one case to lead to a clear change in the witness's demeanour. Your manner towards a number of the witnesses was aggressive, intimidatory and accusatory;
c. When joining proceedings from home, you regularly brought your dog onto the screen in what the panel considered to be a deliberate manner, including when witnesses were present to give evidence which the panel considered to be distracting, unprofessional and discourteous;
d. You were consistently late in re-joining the virtual hearing despite clear instructions having been given regarding the time to return, and regularly kept witnesses waiting for significant periods of time with no apology, including those clearly in uniform who had taken time out of their working days to attend the hearing;
e. You scheduled and accepted a shopping delivery during the course of giving your evidence in chief from home; and
f. You spoke in evidence dismissively and discourteously about colleagues, patients and patients' relatives, both those who had been called to give evidence in proceedings and those who had not.

In the circumstances, the panel accepted the NMC's submissions that there are both historic and continuing attitudinal concerns regarding your practice that have not been remediated.

Having determined that the shortcomings identified in competence and professional conduct have not yet been remediated, the panel determined that it had insufficient evidence to suggest that your lack of competence and misconduct is highly unlikely to be repeated. In fact, it considered the risk of repetition to be high.

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; 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 concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel determined that a finding of impairment on public interest grounds is also required.

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 striking-off order. It noted that this sanction was not available on lack of competence grounds but it considered that the misconduct alone, in this case to be such that a striking-off order is the only appropriate order. It therefore directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor who referred it to the relevant case law which included reference to the case of *Kamberova v NMC* [2016] EWHC 2955 (Admin).

Submissions on sanction

Ms Stevenson, whilst recognising that the decision and sanction was for the panel alone, submitted that the NMC considered a striking-off order to be the appropriate sanction.

Ms Stevenson took the panel through the aggravating and mitigating factors, which, in the NMC's view, were present in this case. She then took the panel through each of the sanctions available and submitted why taking no action, a caution order, a conditions of practice order and a suspension order would not be appropriate in view of the previous findings.

You again gave evidence under affirmation. You said that you do have insight and that you would not knowingly cause harm to anybody. You said that you accepted everything put towards you. You requested that the panel did not strike you off. You said that losing your PIN would have huge implications for Woodlands and the residents who are left. You said that the home would inevitably close because of a lack of nurses. You said this would impact on the residents, they would likely have to move and this may cause a deterioration in their health resulting in them passing away. You said you could not live with this.

You said that you had done your medication competencies and been signed off and that you were getting evidence of this sent to the panel secretary. No evidence regarding this arrived by the time the panel had finished its deliberations regarding sanction. Regardless, this was more relevant to the impairment stage which the panel had already determined and handed down.

You accepted that your attitude was not great but explained that this had been out of frustration because of the lack of support provided to you. You said that this was not an excuse.

You said that you considered that a striking-off order would be harsh considering that you had worked for the last two years with no issues or concerns and no medication errors.

You said that you had probably failed people in hospital, that was not your intention and you were truly sorry for that.

You told the panel that you had worked under an interim conditions of practice order (which Ms Stevenson confirmed was imposed on 25 September 2019 and revoked after the second review on 1 September 2020). You explained what this had entailed and that this had been lifted. You said as far as you had understood it '*everything was finalised'* until you got the letter from the NMC in February 2021 with the sanction bid of a striking-off order. You said this surprised you initially as you had thought everything had been concluded.

You called Mr 18, the Area Manager for Woodlands and a former registered nurse, to provide evidence. Mr 18 told the panel that he had worked closely with you when you arrived to work with Midland Healthcare Ltd (the group which ran Woodlands and several other care homes) as you had restrictions on your practice at that point. He said they were a bit bemused as to the possible outcome today as they had not seen any issues that would warrant a suspension. He said that you had done all of your training and had built up a good working relationship within the community.

Mr 18 admitted that he was not fully aware of the charges you faced at this hearing. He said that you had told them that there were issues with your previous employer, including issues of bullying (of you) and that they had made allegations. He said that he did sit down with you and had discussed issues such as missing signatures on MAR charts and

missing medications as well as attitudinal issues. He said that they were shocked that two years on from the initial restrictions you could be suspended, as they had not seen any concerns with your practice. He said that you were not a perfect nurse and that you needed to be aware of your manner, saying that you had *"rough edges".* However, he said in his view there was nothing that was *"beyond redemption".*

Mr 18 admitted he had not seen any of the panel's findings so far.

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 panel had careful regard to your evidence and took into account the evidence of Mr 18 who the panel was aware had no proper knowledge of the charges found proved or the panel's previous findings.

The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- You have demonstrated only limited insight and insufficient evidence of remediation;
- A pattern of lack of competence and misconduct over a significant period of time and in a number of different settings (both in acute hospital settings and community settings) and workplaces despite extensive support;
- Your actions and behaviour put patients at a significant risk of harm;
- Your behaviour impacted on colleagues, patients and their families as well as the reputation of the profession;

- There is evidence of attitudinal concerns;
- There has been evidence of a consistent lack of regard for and failure to understand policies and procedures.

The panel also took into account the following mitigating features:

- You have started to develop insight during the course of this hearing;
- You have apologised to the panel for your actions;
- Your commitment to Woodlands throughout the Covid crisis;
- Personal mitigation with regards to your health and personal circumstances.

The panel was aware that it could impose any of the following sanctions: take no action, make a caution order for a period of one to five years, make a conditions of practice order for no more than three years, make a suspension order for a maximum of one year, or, with regard to the misconduct, make a striking-off order.

The panel considered the potential sanctions in ascending order of restrictiveness.

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 misconduct was not at the lower end of the spectrum and that a caution order 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 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 considered that there were potentially workable conditions which may address the concerns regarding your lack of competence. However, the panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the misconduct charges found proved in this case. The panel considered that the misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate where some of the following factors are apparent:

- *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 or 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 rather it considered that the facts found proved demonstrated a pattern of unprofessional behaviour over a period of some three years and which has been demonstrated to the panel in your approach to this hearing. The panel considered that there is evidence of deep-seated attitudinal problems relating to your professionalism, including a lack of respect for authority and an unwillingness or inability to accept advice and guidance or follow policies and procedures. Further, the panel has identified that, due to the insufficient evidence of insight or remediation, there is a significant risk of you repeating this behaviour. It was mindful of its

findings that you demonstrated a lack of empathy and a lack of self-awareness or understanding as to how your behaviour comes across to others.

The panel considered that the conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse and in this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction to protect the public or address the public interest in this case.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife 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?*

The panel was of the view that the findings in this case raised fundamental concerns about your professionalism.

The panel determined that your actions, as highlighted by the facts found proved, were significant departures from the standards expected of a registered nurse. The panel considered that the serious breach of the fundamental tenets of the profession evidenced by your misconduct is fundamentally incompatible with you remaining on the register. Patients and the public would expect a nurse to behave professionally. It reminded itself that you had been described as confrontational, hostile, aggressive, rude, flippant and uncaring. The panel was of the view that these behaviours do not reflect the fundamental tenets of the profession and were deeply concerning descriptions of a nurse.

The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising 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 appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was 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 standards of behaviour required of a registered nurse.

This will be confirmed to you in writing.

Interim order

As the striking-off 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 is in your interest until the striking-off sanction takes effect. The panel accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Stevenson. She submitted that an interim suspension order, for a period of 18 months, should be made to cover the appeal period. She submitted that this was appropriate given the panel's findings.

You made no submissions in respect of the interim order.

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. In reaching the decision to impose an interim order, the panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order.

The panel concluded that not to make such an order would be incompatible with its earlier findings and with the substantive sanction it has imposed. The panel first considered whether it was appropriate to impose an interim conditions of practice order, but considered that this was not appropriate for the reasons identified at the sanction stage.

The panel therefore decided to impose an interim suspension order for the same reasons as it imposed the substantive order and to do so for a period of 18 months in light of the likely length of time that an appeal would take to be heard if one were lodged.

In reaching its decision the panel bore in mind the effect of its order on you, professionally and financially. The panel was satisfied that the order is appropriate and proportionate and properly balances the impact of the order on you and the need to protect the public and to meet the public interest.

The panel was mindful of the fact that you are currently on shift as the only registered nurse at Woodlands. It would make clear that you are no longer permitted to work as a

registered nurse and that registered nursing cover for the remainder of your shift is required.

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

This determination will be confirmed to you in writing.

That concludes this determination.