Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday 27 – Friday 29 October 2021
Monday 10 January 2022

Virtual Meeting

Name of registrant:	Anne Marie Quinn
NMC PIN:	78Y0151E
Part(s) of the register:	Registered Nurse RN1 Adult Nurse (April 1994) RN2: Adult Nurse, Level 2 (November 1980)
Area of registered address:	Lancashire
Type of case:	Misconduct
Panel members:	Melissa D'Mello (Chair, Lay member) Manjit Darby (Registrant member) Georgina Wilkinson (Lay member)
Legal Assessor:	Gareth Jones
Panel Secretary:	Sherica Dosunmu (27-28 October 2021) Max Buadi (29 October 2021) Tyrena Agyemang (10 January 2022)
Facts proved by admission:	Charge 3
Facts proved:	Charges 1, 2a, 2c, 4
Facts not proved:	Charges 2b
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (6 months) with a review**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of the meeting that Mrs Quinn was not in attendance and that notice of the substantive meeting had been sent to Mrs Quinn's home address by recorded delivery on 16 September 2021. There was also confirmation that the documents sent to Mrs Quinn had been signed for on 17 September 2021.

The panel took into account that the notice of the substantive meeting provided details of the allegations, as well as the date and time for the substantive meeting.

The panel accepted the advice of the legal assessor.

In the light of all of the available information, the panel was satisfied that Mrs Quinn had been served with notice of the substantive meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you a registered nurse:

1) On 26 June 2018, failed to administer insulin to Patient A. **[PROVED]**

2) In relation to Patient B, on 5 February 2019, in regard to a magnesium infusion/intravenous fluid:

    a) Failed to make any or any adequate check(s) regarding the administration of an intravenous fluid; **[PROVED]**
    b) Failed to administer the correct intravenous fluid; **[NOT PROVED]**
    c) Failed to ensure the correct intravenous fluid was administered. **[PROVED]**

3) On 15 July 2019, administered a nebulised medicine (with adrenaline) to Patient C, using the incorrect route, namely via an intravenous route. **[PROVED BY ADMISSION]**

4) On 22 July 2019, did not ensure Patient D received personal care, in that you left her in a soiled condition. **[PROVED]**

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

Background

On 1 August 2019 the Nursing and Midwifery Council (NMC) received a referral from Bolton NHS Foundation Trust (the Trust). At the time of the concerns raised in the referral, Mrs Quinn was working as an agency nurse at The Royal Bolton Hospital (the Hospital).

The referral alleged that on 15 July 2019, Mrs Quinn administered a nebulised medication to Patient C via an intravenous route resulting in serious harm. In particular, Patient C suffered a cardiac arrest and required defibrillation and admission to a critical care unit.

It was further alleged that prior to the aforementioned incident, Mrs Quinn was involved in two other incidents relating to medication administration, the details of which are set out below.

On 26 June 2018, while working on a shift as an agency nurse, Mrs Quinn was responsible for the care of a total of eight patients. Six of the patients were in a bay on the ward and the other two patients, one of whom was Patient A, had been placed in side rooms. It was alleged that during this shift Mrs Quinn failed to administer insulin to Patient A, which was a critical part of his treatment.

On 5 February 2019, while Mrs Quinn was on duty as an agency nurse, Patient B required frequent intravenous fluids due to a surgical condition. It was alleged that Mrs Quinn failed to correctly check Patient B's intravenous fluids along with another nurse, which resulted in Patient B being administered IV potassium instead of IV magnesium.

During the course of the NMC investigation a further and final concern was raised in relation to the level of care provided by Mrs Quinn to Patient D. It was alleged that on 22 July 2019, Mrs Quinn did not ensure that Patient D received adequate personal care because she was taken for a CT scan in a soiled condition. On the same day, the Trust escalated the concerns to Mrs Quinn's nursing agency.

Decision and reasons on facts

At the outset of the meeting, the panel noted the Case Management Form that had been completed and signed by Mrs Quinn on 23 August 2019, in which she indicated her response to charges 1 to 3. It was apparent from reading this document, along with other correspondence provided, that Mrs Quinn denied charges 1 and 2 but made full admissions to charge 3. No representations were made in relation to charge 4, which the panel therefore treated as also denied.

In the light of the full admissions made to charge 3, the panel found charge 3 proved by admission. The panel also reviewed the evidence relating to charge 3 and was satisfied that there is sufficient evidence, on the balance of probabilities, to prove the charge.

In reaching its decision on the remaining charges, the panel carefully considered all the documentary evidence provided. The panel also heard and accepted the advice of the legal assessor.

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

Along with the information provided by Mrs Quinn, the panel had regard to all of the documentary evidence and the written statements provided by the following NMC witnesses:

- Ms 1: Ward Manager at The Royal Bolton Hospital, who completed an incident report in relation to Patient A;

- Ms 2: Consultant Anaesthetist at The Royal Bolton Hospital, who was the on-call anaesthetist who assessed Patient B;

- Ms 3: Registered Staff Nurse at The Royal Bolton Hospital, who was also responsible for the care of Patient C;

- Ms 4: Ward Manager at The Royal Bolton Hospital, who completed an incident report in relation to Patient C;

- Mr 1: Recruitment Consultant at Service Health Care, who managed bookings/complaints with the agency in relation to Mrs Quinn;

- Ms 5: Registered Staff Nurse at The Royal Bolton Hospital, who was

	present during Patient C's emergency;
• Ms 6:	Ward Manager at The Royal Bolton Hospital, who completed an incident report in relation to Patient D.

Having carefully considered all of the documentary evidence and witness statements, the panel made the following findings in relation to each of the disputed allegations.

Charge 1

1) On 26 June 2018, failed to administer insulin to Patient A.

This charge is found proved.

In reaching this decision, the panel considered the evidence of Ms 1 and Mrs Quinn's statements detailing her recollection of the incident on 26 June 2018. The panel also considered the documentary evidence exhibited for Patient A, which included a Medicine Administration Record Sheet (MARS) chart and an Incident Details Report, dated 28 June 2018.

The panel noted from the written responses provided by Mrs Quinn that she does not dispute that she was working on 26 June 2018 in her capacity as an agency nurse. Instead, Mrs Quinn maintains that she was not informed during the handover that she had responsibility for the patients in the side rooms.

The panel first considered whether it was Mrs Quinn's duty to administer insulin to Patient A on 26 June 2018. In Ms 1's written evidence, she stated that Mrs Quinn was the only registered nurse responsible for the eight patients handed over by Ms 1, which

included Patient A. The panel observed from the MARS chart relating to Patient A that insulin was prescribed as part of his treatment. It was also apparent from the MARS chart that other nurses had administered insulin to Patient A both before and after Mrs Quinn's shift. The panel was therefore satisfied that it was Mrs Quinn's duty to administer insulin to Patient A on 26 June 2018.

Additionally, the panel noted that there was no entry in Patient A's MARS chart to confirm that Mrs Quinn had administered insulin to Patient A when she was the nurse in charge of his care on 26 June 2018. The panel was satisfied by the absence of such information, that Mrs Quinn had not administered insulin to Patient A as alleged.

The panel next considered whether Mrs Quinn was aware of her duty to administer insulin to Patient A on 26 June 2018. On that issue, the panel noted the evidence of Ms 1 that Mrs Quinn was aware from the handover that she had responsibility for the six patients in the bay and the remaining two patients in the side rooms.

The panel noted that the evidence provided by Ms 1 was in contrast to the information provided by Mrs Quinn however the panel attached greater weight to the evidence of Ms 1.

The panel considered that Ms 1's evidence was cogent in that she had spent more time providing Mrs Quinn with full details of the handover because she was aware that Mrs Quinn was an agency nurse:

> '*On 26 June 2018 I was supervisory in the morning and I was working a long day. The Registrant was working on the early shift. I remember handing over to her because often the end of shift handover doesn't contain enough detail for an agency nurse who was not working on that ward every day. I handed over to her a team of 8 patients. There were 6 patients in a bay and 2 patients in the side rooms.'*

The panel determined that the approach taken to the handover described by Ms 1 was credible because her role as Ward Manager meant that she had to ensure that certain standards of care, including patient safety from a nursing perspective, were upheld and maintained throughout the ward. The panel also found the evidence of Ms 1 to be consistent with the contemporaneous Incident Details Report concerning Patient A, which is dated 28 June 2018. Further, when subsequently it was put to Ms 1 by the matron that Mrs Quinn had said that she did not know that the side rooms were her responsibility, Ms 1 confirmed that she had handed over the side rooms to Mrs Quinn.

Whilst the panel also noted that Mrs Quinn had been consistent in her responses to the allegation involving Patient A, she had not provided any information about what she stated was discussed at the handover, which was in contrast to the evidence of Ms 1. The panel noted from Ms 1 and Mrs Quinn's written evidence that she was an agency nurse doing three long shifts a week on different wards in the Hospital. The panel took into account the fact that Mrs Quinn had worked on the same ward on the previous week (19 June 2018).

The panel therefore considered that it was more likely than not that Ms 1 had given an accurate account of what was discussed at the time of the handover and concluded that, on the balance of probabilities, Mrs Quinn failed to administer insulin to Patient A on 26 June 2018.

Accordingly, the panel found charge 1 proved.

Charge 2a)

2) In relation to Patient B, on 5 February 2019, in regard to a magnesium infusion/intravenous fluid:

    a) Failed to make any or any adequate check(s) regarding the administration of an intravenous fluid;

This charge is found proved.

In reaching this decision, the panel had regard to the information provided by Mrs Quinn that whilst she recalled signing for the intravenous fluid, she *"did not put the infusion"* for Patient B.

The panel also considered (i) the evidence of Ms 2 (ii) the documentary evidence exhibited for Patient B, which included a MARS chart, a History Sheet with the patient's notes, and an Incident Details Report dated 5 February 2019 (iii) the Trust's Medicines Policy and (iv) an exhibited document detailing the shifts undertaken by Mrs Quinn.

The panel noted from the document detailing the shifts undertaken by Mrs Quinn that she had completed two split-shifts on 5 February 2019.

The panel noted that the Incident Details report dated 5 February 2019 regarding the error in the administration of Patient B's intravenous fluid details another registered nurse as the '*Giver*' and Mrs Quinn as the '*Checker*'.

The panel considered the following sections of the Trust's Medicines Policy applicable to Mrs Quinn's responsibilities as Patient B's second checker:

> *'**Checking of medications in both Bed Based & Community settings***
> *7.19 Full accountability for the correct administration of the medicine lies with the administering practitioner, unless checking with another registered practitioner and in this case, both are equally accountable. In no circumstances can accountability be delegated to a student or support staff.*
>
> ***Second Person Check in Bed Based Services***
> *7.21 A second person check is required for the following:*
> *[…]*
>
> - *Intravenous injections whether bolus or infusion.*

[...]

Second Person Check in Bed Based Services

7.22 This second person administration check must take place at the patients' bedside. Where this is not possible a local risk assessment should take place and discussed with the Chief Pharmacist.

Preparing Substances for Injection:

7.25 Intravenous solutions must not be prepared for injection in advance of their immediate use, or to administer medication drawn into a syringe or container by another practitioner when not in their presence except:

- *Where they are required to be administered either in quick succession or during a procedure that would result in delay in treatment to prepare the injection. In these situations they must be prepared as close to the procedure as possible and fully labelled with the drug name, concentration and diluent.*

  […]-'

In the light of the Trust's policy, the panel determined that as the second checker, it was Mrs Quinn's duty to carry out adequate checks regarding the administration of Patient B's intravenous fluids.

The panel also accepted the evidence of Ms 2, who was the on-call anaesthetist on 5 February 2019. Ms 2 indicated that after reviewing Patient B's fluid on the 5 February 2019, potassium supplementation was identified, however, Patient B required magnesium supplementation. The panel was therefore satisfied that Patient B did not receive the correct intravenous fluid while under Mrs Quinn's care. The panel was of the view that this finding is supported by the Incident Details report concerning Patient B dated 5 February 2019, which is consistent with Ms 2's evidence that Patient B received incorrect intravenous fluid.

The panel therefore concluded that in accordance with the Trust's Medicines Policy, Mrs Quinn had a duty as a second checker to ensure adequate checks were completed regarding the administration of an intravenous fluid to Patient B and she failed in that duty.

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

Charge 2b)

2) In relation to Patient B, on 5 February 2019, in regard to a magnesium infusion/intravenous fluid:

    b) Failed to administer the correct intravenous fluid;

This charge is found NOT proved.

In reaching this decision, the panel considered documentary evidence exhibited for Patient B, which included a History Sheet with the patient's notes. The panel also considered an exhibited document detailing the shifts undertaken by Mrs Quinn.

As already indicated at charge 2a, the panel noted that Mrs Quinn was on duty on 5 February 2021. However, the panel reminded itself that the Incident Details report dated 5 February 2019 regarding the error in the administration of Patient B's intravenous fluid details another registered nurse as the '*Giver*' and Mrs Quinn as the '*Checker*'.

The panel had not received any other evidence detailing who had administered the intravenous fluid to Patient B. Further there was no evidence before it that Mrs Quinn was the nominated nurse responsible for Patient B on that shift. In the absence of any further evidence, the panel was not satisfied that Mrs Quinn failed to administer intravenous fluid to Patient B on the occasion in question.

Consequently, on the balance of probabilities, the panel found charge 2b not proved.

Charge 2c)

2) In relation to Patient B, on 5 February 2019, in regard to a magnesium infusion/intravenous fluid:

    c) Failed to ensure the correct intravenous fluid was administered.

This charge is found proved.

In reaching this decision, the panel considered the information provided by Mrs Quinn and the evidence of Ms 2. The panel also considered (i) the documentary evidence exhibited for Patient B, which included a MARS chart, a History Sheet with patient notes, and an Incident Details report dated 5 February 2019 (ii) the Trust's Medicines Policy and (iii) an exhibited document detailing the shifts undertaken by Mrs Quinn.

The panel had already found in relation to charge 2a that Mrs Quinn failed in her duty to carry out adequate checks regarding the administration of Patient B's intravenous fluids, and that Patient B did not receive the correct intravenous fluid. While it is not clear from the evidence who had primary responsibility for the care of Patient B, the panel determined from the Incident Details report that Mrs Quinn was certainly involved in Patient B's care insofar as acting as the checker for the administration of the intravenous medication.

The panel noted the information provided by Mrs Quinn that it was common practice in the Hospital for nurses not to check what other nurses were administering to patients:

> *'[…] at Bolton Hospital you do not go with the nurse to check that they are putting up the correct infusion, and no other nurse has ever come with me when I put up an infusion so I do not know what IV the other nurse puts up on the patient.*'

Notwithstanding, in the panel's assessment, there was a duty created by the Trust's Medicines Policy, including at paragraphs 7.19, 7.21, 7.22, 7.25, for all registered nurses involved to ensure the correct administration of intravenous fluid. That being the case, and for the reasons given at charge 2a, as Mrs Quinn did not ensure the correct intravenous fluid was administered to Patient B, the panel was satisfied that, on the balance of probabilities, charge 2c was proved.

Charge 3

3) On 15 July 2019, administered a nebulised medicine (with adrenaline) to Patient C, using the incorrect route, namely via an intravenous route.

This charge is proved by admission.

In the light of the full admissions made to charge 3, the panel found charge 3 proved by admission.

Whilst Mrs Quinn has made full admissions in relation to charge 3, the panel, having reviewed the evidence before it, was satisfied that Mrs Quinn administered a nebulised medication to Patient C using the incorrect route, namely via an intravenous route.

In reaching that conclusion the panel accepted Ms 4's written evidence in which she explained the purpose and function of the nebuliser mask and the way it should have been used for Patient C:

> *'Patient C was admitted into hospital with air way problems and was to be administered adrenaline nebuliser. This involves a mask whereby the adrenaline is converted from liquid into vapour in the mask. This is then inhaled by the patient. In such a circumstance, nothing should be administered intravenously…'*

The panel was satisfied that Mrs Quinn had not administered the adrenaline via the nebuliser to Patient C in the way outlined by Ms 4 in her written evidence.

Charge 4

4) On 22 July 2019, did not ensure Patient D received personal care, in that you left her in a soiled condition.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 6 and Mr 1, together with documentary evidence exhibited for Patient D, which included an Incident Details report dated 5 August 2019 and a complaint email from Patient D's son dated 22 July 2019. The panel also took into account an exhibited document detailing the shifts undertaken by Mrs Quinn.

The document detailing the shifts undertaken by Mrs Quinn confirmed that she was working on 22 July 2019 from 07:30 to 20:00. The panel also noted the evidence of Ms 6's and Mr 1, both of whom gave details of a reported complaint about Mrs Quinn, in relation to the incident on 22 July 2019.

The panel accepted the evidence of Patient D's son that his mother had been left in a soiled condition before being taken for her scan:

> *'[…] I received a call from my mum who was particularly upset, which is not like her (especially with everything that she has been through). She said that she had two bad episodes of abdominal pain and opening her bowels, [...] She said that she had been left in a mess in the morning after the second episode. I arrived on the ward at about 1pm, just as they were taking for her for an echo scan, and I was appalled to see her soiled [...] I was able to clean her myself which took some time. Worryingly, the catheter was covered in faecal matter, from her urethra down to the urine drainage port/balloon port [...]'*

It was clear from the evidence provided by Ms 6, that on 23 July 2019 she became aware of an email sent by Patient D's son on 22 July 2019, in which he raised concerns about the level of care provided to his mother. Specifically, it was reported that Patient D had been sent for a CT scan '*covered in faeces'*. The panel had no reason to doubt the information provided by Ms 6 about the circumstances in which the email was received and a copy of the email was provided.

The panel also noted from the witness statement provided by Ms 6, that after learning of the complaint, she spoke directly with Patient D, who informed her that Mrs Quinn had seen she was covered in faeces but sent her for the scan anyway.

The panel further noted that this complaint was subsequently escalated in an Incident Details Report dated 5 August 2019, in which Mrs Quinn is named as the 'instigator'.

Having regard to all of the evidence, the panel was satisfied that Mrs Quinn did not ensure patient D received personal care while she was on duty on 22 July 2019 and instead left her in a soiled condition.

Accordingly, on the balance of probabilities, the panel found charge 4 proved.

Fitness to practise

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

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

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

Decision and reasons on misconduct

In reaching its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a '*word of general effect, involving some act or omission which falls short of what would be proper in the circumstances*.' The panel also recognised that for the conduct to amount to misconduct, it must be serious.

In assessing whether and to what extent Mrs Quinn had fallen short of the expected professional standards, the panel carefully considered the facts and circumstances of the charges found proved, and the terms of 'The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives 2015' (the Code).

In the Panel's assessment, the conduct found proved fell within two distinct themes namely (1) failures in medication administration and (2) breaches of a duty of care to patients.

Having carefully considered the facts and circumstances of the charged found proved, the panel determined that Mrs Quinn had fallen significantly short of the standards expected of a registered nurse.

In relation to charge 1, Mrs Quinn failed in her duty of care to Patient A by not administering his prescribed insulin. The panel determined that this failure had the potential to cause serious harm to Patient A because insulin was critical for treatment of his condition.

In relation to charge 2, whilst Mrs Quinn maintained that it was not common practice to check medication administered by other nurses, the panel had determined that she was nevertheless under a duty to follow the Trust policy in checking whether appropriate medication had in fact been administered. Furthermore, whilst no actual harm had been caused to Patient B, that was due in part to the fact that she had a surgical condition that required frequent intravenous fluids, including potassium and magnesium. On 5 February 2019, Patient B's blood results (from 3 February 2019) indicated that her potassium levels were within the normal range and that she required only magnesium supplementation. Ms 2's evidence was that Patient B would have been losing potassium as well due to her ileostomy. The panel considered that, had that not been the case, Patient B would have suffered a build-up of potassium in her system, which could have resulted in serious harm.

In relation to charge 3, Mrs Quinn's administration of a nebulised medicine (with adrenaline) via an intravenous route resulted in actual harm to Patient C, who suffered a cardiac arrest. Furthermore, the situation was aggravated by the fact that Mrs Quinn in the initial aftermath, stated that she had administered nebulised adrenaline to Patient C, as opposed to disclosing her error and providing other health care professionals with relevant, timely information to assist them in diagnosing and treating the critically ill patient.

In relation to charge 4, the panel determined that Mrs Quinn had breached one of the fundamental tenants of the nursing profession by failing to provide an effective standard of care to Patient D, who suffered distress and a loss of dignity as a result. Further, Patient D's son had described the extent of his mother's soiling to include, *'the catheter was covered in faecal matter, from her urethra down to the urine drainage port/balloon port…'* The panel considered that this could have put immunosuppressed Patient D at an unwarranted risk of harm.

The panel was reinforced in its view that Mrs Quinn had fallen significantly short of the expected professional standards having identified a number of breaches of the Code. In particular the panel found that the following parts of the Code were engaged:

‘Prioritise people

You put the interests of people using or needing nursing or nursery services first. You make their care and safety your main concern and make sure that their dignity is preserved, and their needs are recognised, assessed, and responded to.

You must:

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

Practice effectively

You assess need and deliver or advise on treatment, or give help (including preventive or rehabilitative care) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

You must:

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

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional ‘duty of candour’ and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

You must:

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

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

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

Promote professionalism and trust

You should uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other healthcare professionals and the public.

You must:

20.1 Keep to and uphold the standards and values set out in the Code'

It was having regard to all of these factors, that the panel determined that both individually and collectively, the charges found proved were sufficiently serious to amount to misconduct and that Mrs Quinn had fallen significantly short of the expected professional standards.

Decision and reasons on impairment

Having found misconduct, the panel next decided whether, in all the circumstances, Mrs Quinn's fitness to practise is currently impaired.

When considering impairment, the NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

The panel accepted the advice of the legal assessor who made particular reference to the judgment in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

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

At paragraph 76 of the judgment in *Grant*, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the misconduct show that [the registrant's] fitness to practice is impaired in the sense that she:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

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

Having carefully reflected on the facts and circumstances of the charges found proved the panel determined that parts a, b and c are engaged in this case.

The panel concluded that Mrs Quinn has in the past acted so as to put patients at unwarranted risk of harm. The panel determined that her failings breached fundamental tenets of nursing practice and that her misconduct is liable to bring the nursing profession into disrepute. In the panel's judgement, the public do not expect a nurse to act as Mrs Quinn did as they require nurses to adhere at all times to the appropriate professional standards and to act to safeguard the health and wellbeing of patients.

The panel however recognised that it had to make a current assessment of Mrs Quinn's fitness to practice, which involved not only taking account of past misconduct but also what has happened since the misconduct came to light. The panel therefore considered whether the concerns identified in Mrs Quinn's nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether Mrs Quinn had provided evidence of insight and remorse.

The panel noted that Mrs Quinn had voiced some regret with regard to charge 1. In an email to the NMC dated 23 August 2019, she stated:

> *'…during my long shift nobody asked about the side room and also the patient did not say anything so unfortunately they were missed their medication which I regret…' [sic]*

Additionally, the panel also considered that Mrs Quinn demonstrated some remorse with regards to charge 3:

> *'…The first most serious incident were I gave Adrenaline IV, at first I did not realise I had done this but when the realisation set in it totally changed my life I am not sleeping cannot eat properly and my family life is suffering…'*

Mrs Quinn also stated that *'she didn't give IV to the patient, had nothing to do with it but feels blamed'.* Further, Mrs Quinn stated that she is *'going to struggle getting a nursnig [sic] job now…'*

However, as demonstrated by the above quotes, the panel considered that the focus of Mrs Quinn's concerns related to the impact the incident had on her and her family, as opposed to the harm it had caused to Patient C. The panel noted again that Mrs Quinn showed a lack of candour in her failure to disclose her error to the healthcare professionals responsible for treating Patient C's cardiac arrest.

In relation to charge 2, it was the panel's view that Mrs Quinn had shown no insight or remorse for her failure to adhere to the Trust's policy but instead relied on the fact that it was not common practice to check medication administered by other nurses.

The panel noted again that there had been no response by Mrs Quinn to the circumstances giving rise to charge 4.

The panel concluded that overall, Mrs Quinn showed very limited insight and remorse, and failed to fully recognise the actual and potential harm that was caused to the patients involved.

In relation to the concerns identified regarding medication administration, the panel considered that, in principle, those concerns were capable of remediation. The panel recognised that Mrs Quinn has provided a certificate from the Healthier Business Group

which provides some evidence of medication administration training in February 2019 (*Handling Medication and Avoiding Drug Errors – level 2)*. Two of the charges found proved and associated misconduct postdate this course. Further, the panel did not have sight of any reflections, or evidence of any steps taken by Mrs Quinn to remediate the shortfalls identified in her practice.

In relation to the concerns surrounding patient care, the panel was of the view that the concerns identified may be remediable. Once again however, the panel considered that no evidence had been provided by Mrs Quinn to demonstrate remorse and appropriate insight into her failings. The panel considered that Mrs Quinn is an experienced nurse and would not expect any patient to be left in the state that Patient D was left in. The panel also noted that on the day of Mrs Quinn's misconduct in respect of Patient D, there is a suggestion of attitudinal concerns. Ms 6 in her statement stated:

> *'…On 22 July 2019 [a] Student on placement from Bolton University, was working on Ward C2. The student reported that the Registrant had told her she was stupid to come into nursing and she should get out when she still could. She said she could not wait to retire as she didn't like nursing anymore...'*

In light of the above, the panel considered that the risk of similar conduct being repeated in the future is high. The panel therefore determined that a finding of impairment is necessary on public protection grounds.

Further the panel had regard to the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

would be undermined if a finding of impairment were not made in the particular circumstances.'

Given the nature and extent of the conduct found proved, which involved multiple failures in medication administration and breaches in patient care, the panel concluded that not to make a finding of current impairment would result in public confidence in the nursing profession and in the NMC as the professional regulator being undermined. The panel was of the view that a fully informed member of the public would be seriously concerned by Mrs Quinn's conduct. The panel therefore determined that a finding of current impairment was also necessary on public interest grounds.

For all the above reasons the panel decided that Mrs Quinn's fitness to practise is currently impaired by reason of misconduct on both public protection and public interest grounds.

Sanction

The panel has considered this case carefully and has decided to make a suspension order for a period of six months, with a review before the expiry of the order. The effect of this order is that the NMC register will show that Mrs Quinn's registration has been suspended.

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.

Decision and reasons on sanction

Having found Mrs Quinn's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had

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

The panel took into account the following aggravating features:

- Very limited insight;
- Several incidents of a similar nature over a period time;
- Some patients harmed and others put at an unwarranted risk of harm, including Patient C's cardiac arrest and Patient D's distress. Further, Patient C's concerns and anxiety about what had caused her cardiac arrest, whether the CPR performed had damaged her breast implants, the health impact the event may have had on her arrhythmia and the inconvenience in needing to cancel a holiday;
- Lack of duty of candour in coming forward promptly regarding the administration of nebulised adrenaline via the incorrect route, namely the intravenous route; and
- An attitudinal concern.

The panel also took into account the following mitigating features:

- There was a common practice within the Hospital not to second check the preparation and administration of medications, albeit outside hospital policy, which may have led Mrs Quinn to believe that it was acceptable to act in the way she did. The panel noted that this is supported in the serious incident report, dated 15 July 2019:

  '…Further investigation was carried out by the investigators who visited ten wards across the organisation and observed similar practice to that which had been reported. Additionally where practice was not observed, staff were asked to share with investigators their practice which confirmed widespread non-adherence to policy….';

The panel considered that the aggravating features outweighed the mitigating factors in this case.

The panel bore in mind that Mrs Quinn is a nurse of 28 years with no previous referrals made to the NMC and that she has engaged with the regulatory process. It also took account of the fact that Mrs Quinn was an agency nurse working on numerous wards in the Hospital and therefore may not have been as familiar with the environment.

The panel placed weight on the highly favourable testimonial provided by Ms 4 dated 20 March 2019. This related to the period in between the events in charges 1 and 2 and the subsequent charges. She stated:

> *'…Anne has worked as a regular agency nurse on my ward for several months. Anne is regarded as a valued member of the team, she is punctual, reliable, caring and empathetic. She has an extensive knowledge of nursing and frequently works alongside out student nurses passing this knowledge on and helping them understand the evidence based rationale behind many aspects of nursing.*
>
> *Anne is competent in all areas of surgical nursing performed on the ward and works well as part of the team whilst also independently, seeking advice from the doctors and escalating concerns to the senior nurse and doctor appropriately.*
>
> *I have received good feedback from both staff and visitors to the ward regarding Anne's work, she is approachable, hardworking and has excellent standards. She is an absolute credit to the profession….'*

The panel also had sight of another testimonial dated 20 January 2021 from a registered nurse who had worked with Mrs Quinn until 1997 and subsequently became friends with Mrs Quinn. The panel noted that the context of them working together was over 20 years before the misconduct arose, so the panel placed little weight on this.

The panel first considered whether to take no action but concluded that this would be incompatible with its findings of current impairment in view of the seriousness of the

clinical failings in this 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 this would be incompatible with its findings of current impairment and the lack of candour during the critical care incident relating to Patient C in charge 3. An order that does not restrict Mrs Quinn's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Quinn's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the potential risks to patients. 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 Mrs Quinn's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel is of the view that, in principle, it may be possible to formulate conditions to address the medication errors and providing an effect standard of care so that patients do not suffer distress nor loss of dignity. However, the panel bore in mind that Mrs Quinn was a very experienced registered nurse who had undertaken inductions at the Hospital and other certified training in February 2019. Notwithstanding, Mrs Quinn failed to follow procedure and protocol and care for patients appropriately. Mrs Quinn also failed to seek advice and support or escalate concerns in order that appropriate medical action could be taken. Additionally, the panel had no evidence before it of Mrs Quinn's willingness to undertake training or comply with conditions of practice. The panel bore in mind that it had determined that Mrs Quinn's had very limited insight and appropriate reflection on her misconduct. The panel therefore determined that there were no workable conditions that could be formulated to adequately protect the public or meet the public interest concerns.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The panel considered that temporary removal from the register is necessary because patients were actually harmed and were put at significant risk of harm by Mrs Quinn's actions. Mrs Quinn had not been transparent in admitting her erroneous action in respect of the nebulised medication in a timely manner. This meant that the intensive care team treating Patient C were not seized of highly relevant clinical information which could have impacted on the speed of diagnosis and the treatment Patient C may have received.

The panel noted that Mrs Quinn had not remediated her misconduct and the serious departures from the Code and, due to the risk of repetition, continued to place patients at unwarranted risk of harm. Furthermore, while Mrs Quinn spoke about the impact on herself and her family, she demonstrated very limited insight and lack of appropriate reflection concerning the impact of her misconduct on patients, the public and the nursing profession. In light of all of these factors, the panel concluded that temporary removal from the register was an appropriate and proportionate response.

In reaching that conclusion the panel noted that while there was an indication of an attitudinal concern relating to Mrs Quinn's derogatory comments about nursing to a student nurse, there is no evidence of her having a harmful, deep-seated personality or attitudinal problems. To the contrary, the panel noted and attached weight to, an exemplary reference given by Ms 4, the Ward Manager regarding Mrs Quinn's knowledge, skills and patient care.

In light of these factors, the panel considered that the registrant's misconduct, while serious, was not fundamentally incompatible with her continuing to be a registered nurse. The panel determined instead that the overarching objective of the NMC would be satisfied by a less severe outcome than permanent removal from the register. Further, the panel considered the public interest in affording an otherwise competent nurse an opportunity to return to safe nursing practice.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

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

The panel noted the possible hardship such an order may cause Mrs Quinn. However, this is outweighed by the public interest in this case.

The panel determined that a suspension order for a period of six months, with a review, was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Reflections on the charges found proved detailing the impact Mrs Quinn's actions had on patients, colleagues, the public and the nursing profession and the steps Mrs Quinn plans to take to remediate her misconduct;

- Certificates of any training undertaken relating to the charges found proved, particularly with regards to medication administration and the delivery of safe, compassionate and dignified patient care;

- If Mrs Quinn continues to work in a care environment, testimonials from manager(s) who can attest to Mrs Quinn's safe, compassionate and

dignified patient care. Testimonials from manager(s) should incorporate any feedback from patients.

All reflections, certificates and testimonials should be provided to the NMC at least 14 days before the first review of this hearing.

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC that submitted it is necessary for the protection of the public and is otherwise in the public interest for there to be an interim conditions of practice order of 18 months to cover the period before a conditions of practice order (or a suspension order if so ordered) comes into force and for the appeal period, should there be an appeal.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and that it is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the

panel’s determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Mrs Quinn is sent the decision of this meeting in writing.

This will be confirmed to Mrs Quinn in writing.

That concludes this determination.