Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday 19 January 2022

Virtual Meeting

Name of registrant:	**Lisa Wells**
NMC PIN:	18I0005W
Part(s) of the register:	Registered Midwife – 9 October 2018
Area of registered address:	Clwyd
Type of case:	Misconduct
Panel members:	David Evans (Chair, Lay member) Linda Tapson (Registrant member) Nicola Hartley (Lay member)
Legal Assessor:	Ben Stephenson
Hearings Coordinator:	Jennifer Morrison
Consensual Panel Determination:	Accepted
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Caution order (2 years)**
Interim order:	**No order**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Miss Wells' registered email address on 14 December 2021.

As this is a meeting, Miss Wells is not able to attend.

The panel took into account that the Notice of Meeting provided details of the allegations, the time, date and venue of the meeting.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Wells has been served with notice of this 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 midwife:

1. *On 7 February 2019;*
    a. *Failed to carry out or record 4 hourly observations for Patient A.*
    b. *At 10:35 and/or 11:05 administered intravenous medication to Patient A when you had not completed the necessary training to do so.*

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

Consensual Panel Determination

At the outset of this meeting, the panel was made aware that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the Nursing and Midwifery Council (NMC) and Miss Wells.

The agreement, which was put before the panel, sets out Miss Wells' full admission to the facts alleged in the charges, that her actions amounted to misconduct, and that her fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a caution order for a period of two years.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

> *'The Nursing & Midwifery Council and Lisa Wells, PIN 18I0005W (collectively "the Parties") agree as follows:*
>
> *1. Ms Wells is content for her case to be dealt with by way of a consensual panel determination ('CPD') meeting. Ms Wells understands that if the panel determines that a more severe sanction should be imposed, the panel will adjourn the matter for this provisional agreement to be considered at a CPD hearing.*
>
> ***The charge***
>
> *2. Ms Wells admits the following charges:*
>
> *That you, a registered midwife:*
>
> *1. On 7 February 2019;*
>
> *a. Failed to carry out or record 4 hourly observations for Patient A.*

b. *At 10:35 and/or 11:05 administered intravenous medication to Patient A when you had not completed the necessary training to do so.*

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

The facts

3. *Ms Wells is a registered midwife. She entered the NMC's register of nurses, midwives, and nursing associates on 9 October 2018.*

4. *On 25 July 2019, the NMC received a referral from Betsi Cadwaladr University Local Health Board ("the Referrer") concerning Ms Wells' fitness to practise. The Referrer employed Ms Wells as a newly qualified midwife in October 2018 on a 6-month temporary contract. At the material time, Ms Wells was in her preceptorship period working at Wrexham Maelor Hospital's Maternity Unit ("the Unit"). As a result of the concerns raised, Ms Wells' temporary contract was not renewed at the end of the 6-montnh contract.*

5. *The referral raised concerns in relation to:*

- *On 7 February 2019, a failure to carry out observations on a patient.*
- *On 7 February 2019, administering intravenous ("IV") medication without completing the requisite competency.*
- *On 14 February 2019, failure to prime an IV line.*
- *On 18 April 2019, failure to recognise and escalate a deteriorating patient.*
- *On 22 April 2019, failure to escalate an abnormal CTG (cardiotocograph).*

6. *The NMC investigated the allegations and referred the following regulatory concerns to the Case Examiners:*

- *Record keeping concerns (7 February 2019 incident);*

- *Administering IV medication outside of your scope of practice (7 and 14 February 2019 incidents); and*

- *Failing to escalate an abnormal CTG trace. (18 and 22 April 2019 incidents)*

7. *The Case Examiners considered the available evidence, including statements of 5 witnesses, and Ms Wells' responses, which contained her full admissions. On 14 June 2021, they determined that Ms Wells had a case to answer in relation to the first 2 regulatory concerns only and referred those matters to the Fitness to Practise Committee for adjudication.*

8. *In relation to the third regulatory concern the Case Examiners decided that there was insufficient evidence to find a case to answer in relation to an incident on 22 April 2019, stating the following:*

> *'We have seen the witness statement of […] who says that you approached them at the nurse's station and that you "did not like the look of the CTG trace." […] states that she would have expected you to tell her more information. In their witness statement they say, "I would have expected (you) in this situation to come to me and tell me exactly what was wrong with the CTG and to say what actions were required. Instead she said 'I don't like the look of that trace' which isn't an appropriate response.*
>
> *While we note that you could have used different language and been more specific as to what was wrong with the CTG, we consider that the evidence is insufficient to suggest that you did not escalate an abnormal CTG. […] was your mentor during your informal capability programme, and you informed them that Patient D's CTG trace did not look right, and indicated that you wanted them to review it.*

Consequently, we have decided that there is insufficient evidence that regulatory concern 3 would be found proven.'

9. *The Case Examiners made no specific comments in relation to the 18 April 2019 incident, when it is said Ms Wells failed to escalate an abnormal CTG. Ms Wells stated that she did not hear the deceleration in the heartbeat (CTG output), noting that at the material time she was focusing on writing out a blood form in the patient's room where there was music and family conversation/laughter. There is no evidence to suggest that Ms Wells heard the deceleration, which was picked up by a colleague and resolved immediately by readjusting the patient's position.*

10. *The Case Examiners did not specifically consider, nor close, a regulatory concern relating to the incident on 14 February 2019 when it is said Ms Wells failed to prime an IV line. Ms Wells was not permitted to administer IV medication and sought her colleague's assistance in setting up the IV for the patient. Therefore it cannot be said that she administered IV medication outside of her practice, nor that she failed to prime an IV line.*

11. *The charges at paragraph 2, above, represent the regulatory concerns that have been referred to the Fitness to Practise Committee by the Case Examiners. Other incidents that had not been explored or commented upon by the Case Examiners have been considered but not charged for the reasons set out at paragraphs 9 and 10, above.*

Facts relating to charge 1.a

12. *On 7 February 2019, Ms Wells was caring for Patient A who had undergone an emergency caesarean section at 02:06 that morning. Patient A, who was in the post-operative period, had significant risk factors, which included sepsis and hypertension, and required regular observations.*

13. *The Emergency C-section Policy states that post-operative observations for the first 12 hours should be made 1/2 hourly for the first 2 hours, then 1 hourly for 4 hours if stable. Observations should then take place 4 hourly.*

14. *However, between the hours of 07:15 to 19:00, Patient A's observation charts show no record of observation; Ms Wells was supposed to perform and record observations during this period.*

15. *At 02:29 on 8 February 2019, Patient A was found unresponsive and transferred to the Intensive Care Unit ('ITU') with a diagnosis of possible sepsis and pneumonia. A Datix incident was raised when the lack of observations was discovered, following Patient A's admission to ITU.*

Facts relating to charge 1.b

16. *Ms Wells' preceptorship passport indicates in the 'INTRAVENOUS DRUG ADMINISTRATION' section that:*

> *'As a preceptor assessing this midwives' competence in adding drugs to intravenous fluid infusions, please use the competence descriptors below and 'sign it off' when the midwife has completed the* ***Health Board's Training*** *and has achieved competence in this skill.'*

17. *The above makes it clear that a midwife must not administer IV medication until they have complete the Health Board's injectable medicines training course.*

18. *On 7 February 2019, Ms Wells administered 2 doses of antibiotics intravenously to Patient A. She had passed her clinical competencies, while being supervised by her mentor. However, she had not attended the Health Board's injectable medicines training course, which was a prerequisite prior to administering IV medication without supervision.*

Ms Wells' admissions

19. *In her case management form, dated 30 August 2021 (**Appendix 1**), Ms Wells admits all of the charges and impairment and accepts the evidence of all of the witnesses. In her reflective statement received on 24 October 2021 (**Appendix 2**), in respect of charge 1.a, Ms Wells accepts that she did not carry out the observations and notes the following:*

> *'One of the ladies in my care had a C-Section early hours in the morning, and was on 4 hourly observations. This is policy in order to keep women safe following a C-Section so that any early warning signs of deviation from recovery is picked up at the earliest opportunity and can be treated in order to prevent serious illness, infection, or any adverse events. On this day, during the 5 hours that this lady was in my care, I made a serious failure of not completing a set of observations or documenting them. The following day, the lady was admitted to ITU with suspected sepsis and pneumonia.*

20. *Ms Wells also accepted in her local statement, made at the request of the Matron, (**Appendix 3**) that she did not carry out a full set of observations and failed to record the one observation that she did take.*

21. *In the statement (**Appendix 2**), in relation to charge 1.b, Ms Wells admits the fact that she had administered IV antibiotics without having completed the necessary training; however, she qualifies this by stating the following in the aforementioned document:*

> *'I was not aware that I had to attend a study day in addition to having clinical competencies signed off to be competent. I was aware that I had to complete the Health Board's training, and I believed I had done this throughout the 4 years of training with the health board, as it was the same health board that I had completed my training with, which included*

IV training. As soon as it was pointed out to me that I had to attend a study day, I did so and attended.'

Contextual factors

22. *At the material time, Ms Wells was a newly qualified nurse who was still subject to ongoing preceptorship programme. On 7 February 2021, Ms Wells was handling a heavy workload on a busy and understaffed Unit.*

23. *In relation to charge 1.b, the Parties acknowledge that there may have been some confusion as to Ms Wells' achieved competencies, given that there is evidence suggesting that on 6 February 2021 (the day before the incident in question), Ms Wells' preceptorship passport relating to 'Preparing and administering an IV fluid infusion' and 'INTRAVENOUS DRUG ADMINISTRATION', was signed by her preceptorship mentor confirming that '[…] Lisa Wells has demonstrated competence in this skill'.*

24. *Nonetheless, the Parties agree that Ms Wells has the responsibility to stay informed of the required policies and ensure that she practises in accordance with such. In her statement (**Appendix 2**), Ms Wells specifically notes the importance of communication in this context, when she states the following:*

> *'[…] what I could have done, was have further discussions surrounding the preceptorship booklet to have full clarification of what was expected of me in order to be competent in the skills listed, including administering IV medication. This would have prevented me from unknowingly working outside my limitations.'*

Ms Wells' current employment

25. *As a result of the aforementioned concerns, the Referrer made a decision not to renew Ms Wells' contract and her temporary contract was terminated on 20 May 2019 on the basis that Ms Wells had failed her probation.*

26. Ms Wells is currently employed by the Betsi Cadwaladr University Health Board as a COVID-19 Immuniser.

Misconduct

27. The Parties agree that the charges in this case amount to misconduct for the purpose of these proceedings.

28. The 2 charged incidents occurred on the same shift, whilst Ms Wells was still subject to a preceptorship programme. It is likely that Ms Wells, being a newly qualified midwife, has not yet reached her expected level of competency. However, with only 2 charged incidents of clinical failings and given that Ms Wells has not practised midwifery since May 2019, the NMC does not have a fair sample of Ms Wells' practice for a lack of competence case. For this reason, the Parties agree that the facts, set out in the charges at paragraph 3, amount to misconduct.

29. The parties have had regard to the case of Roylance v General Medical Council (No.2) [2000] 1 AC 311, in which the Privy Council stated that:

> *38. '[…] misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. […] The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious.'*

30. The Parties agree that Ms Wells' actions, as set out in the charges above, a) fell short of what would have been proper in the circumstances; b) are related to the profession of midwifery; and c) can properly be described as serious in that Ms Wells put Patient A at an unwarranted risk of harm.

31. *One of the sources of standards that underpin midwifery practice, as well as the standards that patients and members of the public can expect from health professionals, is The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 2015 ('the Code'). The Parties agree that the following sections of the Code, in place at the material time, were engaged, and breached, in this case:*

> *'Treat people as individuals and uphold their dignity*
>
> *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*
>
> *Always practise in line with the best available evidence*
>
> *6.2 maintain the knowledge and skills you need for safe and effective practice.*
>
> *Work co-operatively*
>
> *8.2 maintain effective communication with colleagues.*
>
> *Keep clear and accurate records relevant to your practice*
>
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
>
> *Recognise and work within the limits of your competence*
>
> *13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*
>
> *13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*
>
> *13.5 complete the necessary training before carrying out a new role*
>
> *Uphold the reputation of your profession at all times*
>
> *20.1 keep to and uphold the standards and values set out in the Code.'*

32. *Ms Wells' conduct referred to in the charges fell short of what would have been expected of a registered midwife and represented a serious departure from the standards contained in the Code, as particularised above.*

33. *The conduct in charge 1.a was serious in that it relates to a failure in respect of a basic, but important aspect of midwifery. Carrying out observations for vulnerable patients is vital to ensuring any signs of deterioration are picked up and acted upon promptly. Failure to undertake observations has potential for serious, unwarranted patient harm, as is evident from the post-operative deterioration of Patient A and their subsequent admission to ITU. Whilst Patient A's deterioration could not be attributed to Ms Well's conduct directly, had the observations been recorded in line with the post-operative plan, it is possible that Patient A's deterioration could have been picked up and escalated sooner, potentially preventing an ITU admission.*

34. *The conduct in charge 1.b is also serious. A midwife must only provide patient care that they are competent, qualified, trained, and authorised to carry out. By administering IV medication to Patient A when she had not received relevant training and authorisation to do so, Ms Wells put Patient A at risk of harm. Whilst it is accepted that Ms Wells may have believed she was permitted to administer IV medication, it is incumbent on registered professionals to ensure they only provide care within the scope of their competence and as authorised by their employer.*

Impairment

35. *The Parties agree that Ms Wells' fitness to practise is currently impaired by reason of her misconduct.*

36. *The Parties have considered the questions outlined by Dame Janet Smith in the Fifth Shipman Report, as to the factors that might lead to a finding of impairment. These questions were summarised by Cox J in the case of Council*

for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 76 in the following terms:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d. […].'*

37. The Parties agree that the first three limbs, namely a, b, and c, are engaged in this matter, in that Ms Wells' actions:

37.1. Placed Patient A at an unwarranted risk of harm.

37.2. Brought the profession into disrepute.

37.3. Breached the fundamental tenets of the profession in so far as they relate to the safe and effective midwifery care.

38. The health and safety of women and their babies is an essential component of high quality midwifery care. Patients who are under observations require these to be conducted with the aim of identifying any deteriorating condition, preventing harm, and assisting other health professionals in their respective duty. Failure to carry out observations effectively can, in some cases, result in serious harm. Furthermore, failure to check such observations can signal a lost opportunity to implement and/or increase measures put in place in an effort to

prevent harm. By failing to carry out the observations for Patient A, Ms Well placed her at risk of unwarranted harm.

39. *Midwives are required to practise safely within their competence, which is a key underpinning principle of the Code. A midwife working outside of their competence could have a significant impact on patient safety, raising the risk of unwarranted harm. By administering IV medication to Patient A when she had not been signed off as competent to do so, Ms Wells put Patient A at risk of unwarranted harm.*

40. *Midwives must promote professionalism; as such, there is a duty to consistently display a personal commitment to the standards of practice and behaviour set out in the Code. Ms Wells' actions, as set out in the charges, brought the midwifery profession into disrepute and had the potential to undermine trust and confidence in the profession. The public rightly expects that registered members of the profession provide a high standard of care at all times and do so in line with their competencies. Failure to adhere to such standards carries with it the risk of damage to the reputation of the profession.*

41. *The provisions of the Code constitute fundamental tenets of the midwifery profession. Breaches of the Code, especially where they relate to basic midwifery practice to provide safe and effective care and to do so within the scope of one's competence, amount to breaches of fundamental tenets of the profession.*

Remediation, insight, and risk of repetition

42. *The Parties considered the case of Cohen v General Medical Council [2008] EWHC 581 (Admin) at paragraph 65 in which Silber J outlined the following questions, which were likely to be 'highly relevant' to the determination of the question of current impairment:*

    42.1. Whether the conduct that led to the charges is easily remediable.

42.2. Whether it has been remedied.

42.3. Whether it is highly unlikely to be repeated.

Can the concern be addressed?

43. The Parties agree that given the limited scope of the charges the conduct could be described as easily remediable, which could be achieved through appropriate reflection, insight, and training. Notwithstanding the seriousness of the failings, the Parties acknowledge that a number of contextual factors (as set out above) were engaged and that Ms Wells' conduct does not arise as a result of an underlying attitudinal concern.

Have the concerns been addressed?

44. Ms Wells has fully engaged with the NMC proceedings and made a number of submissions, first, in response to the regulatory concerns, then, to the schedule of charges and relevant case management matters, and finally in preparation for this CPD. In these responses, Ms Wells has been consistently open and honest about her failings, and demonstrated a significant level of remorse, reflection, and insight in relation to all of the identified concerns. Specifically, she was able to do the following, as outlined in the NMC's guidance on insight – 'FTP-13b Has the concern been addressed?':

- *step back from the situation and look at it objectively*
- *recognise what went wrong*
- *accept their role and responsibilities and how they are relevant to what happened*
- *appreciate what could and should have been done differently*
- *understand how to act differently in the future to avoid similar problems happening*

*45. In her statement (**Appendix 2**), in relation to Patient A and charges 1.a and 1.b, Ms Wells demonstrates significant insight through her ability to recognise the*

seriousness of her failings and their associated risks; and accept her role and professional responsibilities:

> *'I am fully aware that if I had taken her observations when they were due, then there may have been some or at least one early warning indicator that I could have acted upon. As a midwife I had a responsibility to this lady, her baby, and her family to give her quality best available evidence care, and I failed by not completing her observations or documenting them. The standard of care that this lady received was unacceptable. The remorse I feel for not doing this will never leave me. The NMC Code clearly states, 'Always practice in line with best available evidence'. This was a failure on my part as I did not follow the C-Section policy relating to taking 4 hourly observations. Furthermore, I also failed in 'Keeping clear and accurate record' as I did not document. Again, this failing can have serious negative implications to somebody's care, treatment and recovery. Midwives work alongside other health professionals, and documentation is vital for communication. Furthermore, if something is not documented, it did not happen. In addition to these mistakes, I also administered IV antibiotics to this lady without attending the study day. I was not aware that I had to attend a study day in addition to having clinical competencies signed off to be competent. […] As soon as it was pointed out to me that I had to attend a study day, I did so and attended. I have never before worked outside my limitations or competencies. I am aware of how serious this is and would never ever knowingly do this. The Code specifically states 'Recognise and work within the limits of your competence. Again, and unknowingly, failed to adhere to this. When I was a student, there were a few occasions where the midwife would ask me to do something and I politely refused due to reasons including either not being competent to do so, not feeling confident to do so, or because as a student, we were not allowed to do it. I was in a state of shock when I was informed I had not been competent as safety is paramount in caring for individuals.'*

46. *In her statement (**Appendix 2**), Ms Wells demonstrates remorse and accountability for her actions:*

> *'On my next shift following this particular one, I was informed by […] (Midwife) who I had handed this lady's care over to, that the lady was in ITU […]was worried and upset because she had administered the lady's antibiotics 3 hours late […] I suggested to […] that we both go to ITU first and foremost to apologise to this lady as I was absolutely mortified that this poor lady was ill and couldn't help but feel I may have had a part in this, as I recalled I hadn't completed her observations when they were due. I went to see the lady and asked how she was, and I offered my apologies. She told me it wasn't my fault but I did inform her that I had forgotten to go back to her and complete her observations and if I hadn't forgotten, then there may have been an indication that she was becoming ill. The lady tried to reassure me […] Nevertheless, I told the lady that I had made a mistake and I shouldn't have. I still let her down. The lady accepted my apology. I was honest in my failings to this patient, although at this time, I was not aware that I shouldn't have administered her antibiotics.'*

47. *Significantly, Ms Wells spoke to Patient A the following day and offered her apologies for not completing observations, which speaks to Ms Wells' transparency and accountability.*

48. *In her statement (**Appendix 2**), Ms Wells is able to describe what went wrong in relation to charge 1.a and what steps she would take to prevent such failings from ever occurring again. She also provides examples of how she has dealt with similar situations since the events in the charges:*

> *'If I had the time again, this is where I would inform the other midwife, regardless of her banding that I did not feel confident due to the high*

number of high risk patients and babies on transitional care, and that I felt overwhelmed by this workload and if we could arrange an alternative way to share the workload.

In my current role, I have been placed with a patient on a few occasions where I felt I was not experienced enough to be able to meet her needs and felt it would be safer and more beneficial for the patient to be supported by another staff member. The lessons I learnt from the incident in 2019 gave me confidence to speak up and act in the best interest of the patient. I have also experienced a situation where we have been understaffed and I had no hesitation in informing the Managing Director as my concerns were not being addressed by the Manager at that time. I developed confidence to escalate situations where I thought the care given to patients may be substandard amongst other reasons, and I learnt that feeling pressure in the work place, and not speaking up, contributes to mistakes being made.

I would have informed the ward manager that I felt overwhelmed and needed some help, and that I was unhappy with the staffing levels. I would have politely asked the Registrar/ Doctor to wait until I had finished what I was doing (taking observations). Then I would have completed the observations, completed my documentation, and then address the registrar's request. The other option I had was to go and find someone to continue doing the lady's observations whilst I attended to the lady in bed 2 with the registrar/doctor. The documentation of the observations would have also been completed.
Due to the coaching I received, and lessons I learnt from 2019, I have in my current employment been confident in asking others to continue a task I had originally started in order to free me up to deal with an urgent matter or emergency. A couple of examples of this include a time where I was carrying out a medication round and a psychiatrist rang the unit

needing to speak to me as I was the person in charge of the shift. I told the member of staff who came to give me the message to politely ask the psychiatrist for a number to call him back on and inform them that I would call back as soon as I could. I took this particular action as a result of my mistake in 2019. I then was able to continue what I was already doing; patients had their medication, I documented, and then rang the psychiatrist back.'

49. *Likewise, in relation to charge 1.b Ms Wells is able to describe what steps she would take to prevent such failings from ever occurring again and provides examples of how she has dealt with similar situations since the events in the charges:*

> *'I had no reason to believe I wasn't competent, but what I could have done, was have further discussions surrounding the preceptorship booklet to have full clarification of what was expected of me in order to be competent in the skills listed, including administering IV medication. This would have prevented me from unknowingly working outside my limitations.*
>
> *As a lesson learnt from 2019, I always question and double check to make sure I am working within my limitations. An example of how I have applied this in my current role is when dealing with challenging behaviour and the patient requiring MAPA (Management of Actual or Potential Aggression). I have only been trained in Basic MAPA Training. This usually means a 2 person hold. However, when a patient is off baseline and displaying signs of potential violence, they require staff who are Advanced MAPA Trained. There was an incident on one occasion when I was on shift where the 2 person hold was not working and instead aggravating the patient further so I instructed my colleague to disengage from the hold. I called for help as the patient was requiring advanced techniques. When help arrived, I was instructed to hold the patient in a*

way I had not been shown so I questioned this and when I was asked if I was advanced trained, I replied no. The member of staff said she would guide me but I refused as I was not trained in this area. As a result of this incident this day, it is now a requirement of the company that all staff are Advanced MAPA Trained. Although I would have been assisting my colleagues, and de-escalating the situation in a timelier manner, I had not received the appropriate level of training so refused. I followed the company policy for the safety and wellbeing of the patients.'

50. *In addition to the above, Ms Wells submitted the following documents – a copy of her local statement (**Appendix 3**) and 2 reflective accounts forms (**Appendix 4**). These provide further context to charged incidents and lessons learned.*

51. *Following the incidents of 7 February 2019, Ms Wells was placed on an informal capability programme for a period of 8 weeks. Ms Wells has produced a copy of her 'STAGE-Development programme' (**Appendix 5**), demonstrating her set objectives and actions taken to achieve said objectives, including completing IV additives competencies, which was done on 25 April 2019. Additional training certificates have been produced by Ms Wells (**Appendix 6**); however the Parties agree, given that Ms Wells has not practised midwifery since May 2019, these may not be relevant to determining her current impairment, though they clearly demonstrate Ms Wells' continued efforts to improve her practice.*

52. *Ms Wells has also provided 2 testimonials (**Appendix 7**). One comes from a colleague with whom Ms Wells has worked with in a care setting in a non-midwifery role, who was also a midwifery patient of her prior to them working together. In the testimonial her colleague states as follows from her perspective as a patient:*

> *'I've known Lisa in the capacity as patient as well as colleague. In 2017 Lisa Wells was part of the midwifery team that delivered my daughter via*

emergency c-section. The following morning, Lisa had made a point of finding me to ask how I was, offered warm words of reassurance, put me at ease and made me laugh with her brilliant sense of humour.'

53. *From her perspective as a colleague, she states:*

> *'I was immediately impressed again with Lisa's kind manner and adaptability in making our residents feel safe and supported. I encouraged Lisa to join our team on a permanent basis and was thrilled when she accepted. Due to Lisa's dedication and passion for improving the lives of our residents she was quickly promoted to team leader where she proved to be a huge help to myself, as deputy manager and supported the whole team. Lisa worked tirelessly to exceed all expectations of the job role and dealt with many challenging situations with professionalism and understanding at all times.*
>
> *On the whole, I find Lisa to be incredibly hard working, kind, caring, knowledgeable and supportive. Lisa is a good friend as well as a valued colleague.*

54. *In the second testimonial, also from a colleague with whom Ms Wells worked with in a care setting in a non-midwifery role, it states:*

> *'I have always found Lisa to be honest, hardworking and dedicated to providing the best care possible to the people we support. As a team leader Lisa would ensure that shifts were planned, medication was administered correctly, and all documentation was completed correctly and in a timely manner.*
>
> *Lisa is caring, approachable and has great people skills which are all valuable attributes.'*

Is it highly unlikely that the conduct will be repeated?

55. *Ms Wells has not practised midwifery since her referral to the NMC, as such there is no independent evidence to support that she can practise in a safe and effective manner. However, it must be said that the concerns have been addressed substantially by way of Ms Wells' significant level of reflection and insight, making it highly unlikely that the matters charged in this case would be at a risk of repetition. Further, the testimonials provided, albeit not relating to her practise as a midwife, indicate the Ms Wells is passionate, professional and dedicated to providing the best care. Again, such indicates that it is highly unlikely she would find herself making errors in her practice again.*

Public protection impairment

56. *In light of Ms Wells' reflection, significant insight, and steps taken to strengthen her practice, the Parties agree that the risk of repetition of future misconduct of the kind found in this case has been greatly reduced. Whilst the Parties acknowledge the seriousness of misconduct in this matter, including the potential for significant patient harm, the contextual factors, as referred to above, together with the limited risk of repetition is such that a finding of impairment on pubic protection grounds, as of today's date, is not required.*

Public interest impairment

57. *The parties agree that this is a case where a finding of current impairment is required to declare and uphold proper professional standards and protect the reputation of the nursing profession. This is in accordance with the comments of Cox J in Grant at paragraph 101:*

> *The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be*

undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case.

58. *The NMC's guidance 'FTP-3 How we determine seriousness' notes the following:*

> *Sometimes we may need to take regulatory action against a nurse, midwife or nursing associate not because their practice presents a risk of harm to patients, but because of our objectives to promote and maintain professional standards and public confidence in nurses, midwives and nursing associates*

59. *The full seriousness of the regulatory concerns has been identified and is accepted by the Parties. Whilst the considered likelihood of repetition is relatively low and the risk of harm is significantly reduced, the Parties recognise that a finding of impairment is required to address the public interest in this case. The charges in this case demonstrate significant failings, presenting a real risk of unwarranted harm to patients. A finding of impairment is required to send a clear message that even newly qualified midwives must provide safe and effective care at all times, and that they must ensure they act within their scope of competence.*

60. *As such, the Parties agree that in order to protect the wider public interest a finding of impairment is necessary to uphold proper professional standards and public confidence in the profession and the NMC as its regulator. Without a finding of impairment, public confidence in the profession and the NMC would be seriously undermined.*

Sanction

61. *The Parties agree that the appropriate sanction in this case is a* ***caution order for a period of 2 years****. The Parties have considered the NMC's Sanctions Guidance and note that this is Ms Wells' only referral.*

62. *In terms of aggravating factors, the Parties acknowledge that Ms Wells actions, referenced at charges 1.a and 1.b, put Patient A at risk of unwarranted harm.*

63. *The mitigating features of the case are as follows:*

- *Ms Wells' early admissions and transparency throughout the local and the NMC proceedings.*
- *The significant reflection and insight, which indicates that the risk to patient safety to has been reduced.*
- *The charges are limited to a single shift.*
- *The charges relate to a period when the registrant was newly qualified.*
- *The lack of evidence of any attitudinal issues or deliberate failings.*
- *The Unit being understaffed at the material time.*
- *Confusion over the completed IV medication administration competency.*
- *Ms Wells' capability plan to address the first concern was not completed due to her contract not being renewed as a result of subsequent allegations, which were not considered capable of proof by the NMC's Case Examiners.*

64. *In deciding what sanction would be appropriate, the Parties first considered whether this is a case in which it would be appropriate to take no further action. The Parties agreed that this would not be sufficient to address the public interest considerations in this case. The misconduct was clearly serious and needs to be marked so as to maintain confidence in the nursing profession and its regulator, and to publicly declare and maintain proper standards of conduct and behaviour.*

65. *The Parties next considered whether a caution order would be appropriate. NMC's Guidance 'SAN-3b Caution order' states as follows:*

A caution order is the least serious of our sanctions in that it is the least restrictive.

A caution order is only appropriate if the Fitness to Practise Committee has decided there's no risk to the public or to patients requiring the nurse, midwife or nursing associate's practice to be restricted, meaning the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise committee wants to mark that the behaviour was unacceptable and must not happen again.

Because a caution order doesn't affect a nurse, midwife or nursing associate's right to practise, the Committee will always need to ask itself if its decision about the nurse, midwife or nursing associate's fitness to practise indicated any risk to patient safety.

If it did, the panel members will then have to ask themselves whether a caution order will be enough to protect the public, given that it would allow the nurse, midwife or nursig (sic) associate to continue to practise without any restriction.

66. *The Parties agree that although serious, Ms Wells' misconduct is capable of remedy and Ms Wells has demonstrated, through significant insight and reflection evidenced in the appended documents, that any risk of repetition has been greatly reduced. Accordingly, this case is situated at the lower end of the spectrum of impaired fitness to practise. As such, in light of the finding that there is no public protection impairment, a caution order is appropriate. A caution order will allow Ms Wells to return to practice as midwife, whilst serving to mark the serious nature of her misconduct. The Parties agree that such an outcome would be sufficient to maintain public confidence.*

67. *The Parties next considered whether a conditions of practice order would be appropriate. NMC Guidance SAN-3c Conditions of practice order states as follows:*

When conditions of practice are appropriate

The key consideration for the panel, before making this order, is whether conditions can be put in place that will be sufficient to protect patients or service users, and if necessary, address any concerns about public confidence or proper professional standards and conduct.

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

- *no evidence of harmful deep-seated personality or attitudinal problems*
- *identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining*
- *no evidence of general incompetence*
- *potential and willingness to respond positively to retraining*
- *the nurse, midwife or nursing associate has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision*
- *patients will not be put in danger either directly or indirectly as a result of the conditions*
- *the conditions will protect patients during the period they are in force*
- *conditions can be created that can be monitored and assessed.*

68. *The Parties agree that there are no longer any identifiable areas of Ms Wells' practice in need of assessment and/or retraining. Although she has not worked in a midwifery role since the incidents on 7 February 2019, she has demonstrated that she has sufficiently strengthened her practice in the limited*

areas of concern raised in the charges through significant reflection, such that a conditions of practice order is not required to protect patients. As such, a conditions of practice order would not be proportionate as it is not required for public protection.

69. *The Parties have considered the NMC's Guidance 'SAN-1 Factors to consider before deciding on sanctions', which states the following in relation to proportionality:*

> *Being proportionate means finding a fair balance between the nurse, midwife or nursing associate's rights and our overarching objective of public protection. We need to choose a sanction that doesn't go further than we need to meet this objective. This reflects the idea of right-touch regulation, where the right amount of 'regulatory force' is applied to deal with the target risk, but no more.*

70. *The NMC notes that the Case Examiners identified public protection concerns in this case and the absence of any evidence of Ms Wells' safe midwifery practice, due to her currently not working in the field. However, the Parties are satisfied that the public protection concerns are no longer made out on the basis of Ms Well's reflection, which is appended to this CPD agreement and, although a conditions of practice order may seem desirable, given that Ms Wells has not practised as a midwife since 2019, it is simply not proportionate for conditions to be imposed under the circumstances.*

71. *Taking into account Ms Wells' engagement, insight, and efforts to address the identified concerns, the serious features of the case can be appropriately recognised by the length of the caution order, which should be for the duration of 2 years.*

72. *As such, the Parties agree that the appropriate and proportionate sanction in this case is a caution order, which will remain on Ms Wells' registration for a duration of 2 years. This sanction will appropriately mark the misconduct in this*

case and will adequately satisfy the wider public interest considerations. It will also serve as a notice to prospective employers that there has been an issue with Ms Wells' practice in the past, which would allow them to consider and, if necessary, put in place necessary provisions to support her return to midwifery practice.

Referrer's comments

73. The NMC invited the Referrer to comment on the proposed sanction. On 12 November 2021, the NMC received an email from the Referrer noting the following response from the Head of Midwifery:

> *'This case refers to a midwife who worked in Wrexham, who was subject to the capability policy and did not complete this. I would have reservations about her being able to practice as a midwife with no conditions.'*

74. Whilst, of course, the panel should take those comments into account when determining the appropriate sanction in this case, it should recognise that the case before it relates to fewer concerns than those raised by the Referrer.

75. The panel should also bear in mind that Ms Wells was unable to complete her capability programme as her employment was terminated following additional concerns. The Case Examiners later found these concerns to be lacking sufficient evidence necessary to establish a case to answer.

Interim order

76. An interim order is not required on this case as there is no finding of impairment on public protection grounds and a caution order is agreed to be the appropriate sanction.

The Parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The

parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.

List of accompanying documents

Appendix 1 – Completed CMF
Appendix 2 – Reflective statement
Appendix 3 – Local statement
Appendix 4 – Reflective accounts forms
Appendix 5 – Capability package
Appendix 6 – Training certificates
Appendix 7 – Character references'

This is the end of the provisional CPD agreement between the NMC and Miss Wells. The provisional CPD agreement was signed by Miss Wells and the NMC on 30 November 2021 and 10 December 2021 respectively.

Decision and reasons on the CPD

The panel decided to accept the CPD.

The panel heard and accepted the legal assessor's advice. He referred the panel to the NMC Sanctions Guidance ('SG') and to the NMC's guidance on CPDs. He reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Miss Wells. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel noted that Miss Wells admitted the facts of the charges. Accordingly, the panel was satisfied that the charges are found proved by way of Miss Wells' admissions as set out in the signed provisional CPD agreement.

Decision and reasons on impairment

The panel then went on to consider whether Miss Wells' fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Miss Wells, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of misconduct, the panel determined that Miss Wells' actions, as set out in the charge, fell short of what would have been proper in the circumstances, are related to the profession of midwifery, and can properly be described as serious, in that Miss Wells put Patient A at an unwarranted risk of harm.

In this respect, the panel endorsed paragraphs 27 to 34 of the provisional CPD agreement in respect of misconduct.

The panel then considered whether Miss Wells' fitness to practise is currently impaired by reason of misconduct. The panel determined that Miss Wells' fitness to practise is currently impaired by reason of misconduct, in that Miss Wells placed Patient A at an unwarranted risk of harm, brought the profession into disrepute, and breached the fundamental tenets of the profession insofar as they relate to safe and effective midwifery care.

The panel considered whether the misconduct was remediable, and whether Miss Wells has addressed the concerns about her practice. Notwithstanding the seriousness of the misconduct, the panel acknowledged the contextual factors that were present, which

included being a newly qualified midwife, being moved to a different area of work on a very busy ward that was short-staffed, and being allocated to a particularly high-risk patient. The panel was satisfied that Miss Wells' misconduct did not arise as a result of an underlying attitudinal concern.

The panel noted that Miss Wells had fully engaged with the NMC throughout these proceedings. It noted that Miss Wells had recognised the seriousness of her failings and the impact on Patient A, and clearly articulated what she should have done differently. Whilst the panel took into account that there was some potential confusion as to whether Miss Wells had been deemed competent at the time to administer an IV infusion, it appreciated that it was ultimately Miss Wells' responsibility to ensure that she was informed of relevant policies and to practise in accordance with these. The panel noted that Miss Wells had already accepted this in her reflection:

> '[…] *what I could have done, was have further discussions surrounding the preceptorship booklet to have full clarification of what was expected of me in order to be competent in the skills listed, including administering IV medication. This would have prevented me from unknowingly working outside my limitations*.'

The panel considered that Miss Wells has demonstrated a significant level of insight and remorse in relation to her misconduct, and that she acted in accordance with her duty of candour by speaking to Patient A the following day and offering her apologies for not completing observations. The panel was satisfied that Miss Wells has internalised her learning from the incident, and saw evidence that she has applied it to similar situations since the events in the charges:

> *'[…] In my current role, I have been placed with a patient on a few occasions where I felt I was not experienced enough to be able to meet her needs and felt it would be safer and more beneficial for the patient to be supported by another staff member. The lessons I learnt from the incident in 2019 gave me*

confidence to speak up and act in the best interest of the patient. I have also experienced a situation where we have been understaffed and I had no hesitation in informing the Managing Director as my concerns were not being addressed by the Manager at that time. I developed confidence to escalate situations where I thought the care given to patients may be substandard amongst other reasons, and I learnt that feeling pressure in the work place, and not speaking up, contributes to mistakes being made.

I would have informed the ward manager that I felt overwhelmed and needed some help, and that I was unhappy with the staffing levels. I would have politely asked the Registrar/ Doctor to wait until I had finished what I was doing (taking observations). Then I would have completed the observations, completed my documentation, and then address the registrar's request. The other option I had was to go and find someone to continue doing the lady's observations whilst I attended to the lady in bed 2 with the registrar/doctor. The documentation of the observations would have also been completed.

Due to the coaching I received, and lessons I learnt from 2019, I have in my current employment been confident in asking others to continue a task I had originally started in order to free me up to deal with an urgent matter or emergency. A couple of examples of this include a time where I was carrying out a medication round and a psychiatrist rang the unit needing to speak to me as I was the person in charge of the shift. I told the member of staff who came to give me the message to politely ask the psychiatrist for a number to call him back on and inform them that I would call back as soon as I could. I took this particular action as a result of my mistake in 2019. I then was able to continue what I was already doing; patients had their medication, I documented, and then rang the psychiatrist back.'

The panel noted that Miss Wells has not practised as a midwife since she was referred to the NMC, and as such, there is no independent evidence that Miss Wells is able to practise safely and effectively. However, the panel was satisfied that Miss Wells has done all she can to remediate her practice in the areas that relate directly to the charge. She has undertaken relevant training and given examples of situations that are similar in context, demonstrating how she has changed her practice to preserve patient safety. She gave an example of how she was dealing with a particularly challenging patient requiring physical restraint using actual or potential management of aggression (MAPA). Miss Wells had only been trained in basic MAPA. The incident she was involved in required the advanced techniques. She was instructed to hold the patient in a way she was not qualified to do. Miss Wells questioned this, but was asked to undertake the advanced restraint under guidance. Since she had not received the appropriate level of training, she refused and followed the company policy to ensure the safety and wellbeing of the patient.

The panel are of the opinion that these examples provided by Miss Wells demonstrate her ability to implement what she has learned and, when combined with her significant level of insight and remorse, this considerably diminishes the risk of repetition.

Taking the above into account, the panel agree with paragraph 56 of the provisional CPD agreement, and for the reasons there given, consider that Miss Wells' fitness to practise is not impaired on the grounds of public protection.

Nonetheless, the panel determined that a finding of impairment is required to address the public interest in this case. The charges in this case demonstrate significant failings, presenting a real risk of unwarranted harm to patients. A finding of impairment is required to send a clear message that even newly qualified midwives must provide safe and effective care at all times, and that they must ensure they act within their scope of competence.

In this respect, the panel endorsed paragraphs 35 to 60 of the provisional CPD agreement, and determined that Miss Wells' fitness to practise is impaired on public interest grounds alone.

Decision and reasons on sanction

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

The panel considered the following aggravating features:

- Miss Wells' actions placed Patient A at a risk of unwarranted harm.

The panel also considered the following mitigating features:

- Miss Wells' early admissions and transparency throughout the local and the NMC proceedings.
- The unit was unfamiliar to Miss Wells, was understaffed and very busy at the material time.
- The significant reflection and insight shown by Miss Wells.
- The charges are limited to a single shift.
- The charges relate to a period when Miss Wells was newly qualified.
- The lack of evidence of any attitudinal issues or deliberate failings.
- Confusion over the completed IV medication administration competency; and
- Miss Wells' capability plan to address the first concern was not completed due to her contract not being renewed as a result of subsequent allegations, which were not considered capable of proof by the NMC's Case Examiners.

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

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 noted that Miss Wells has shown significant insight into her conduct. The panel further noted that she made early admissions, and showed evidence of genuine remorse that included a personal apology to Patient A. Miss Wells has consistently engaged with the NMC since the referral was made.

The panel considered whether it would be proportionate to impose a more restrictive sanction and considered a conditions of practice order. The panel considered its earlier finding that the risk to the public had been considerably diminished. It also noted that the concerns, whilst serious, involved a single patient and the incident could be characterised as a 'one-off'. The panel was satisfied that Miss Wells has learned from this experience, and accepted her assurances that an incident of a similar nature would not occur again.

The panel had regard to the referrer's comments about the proposed sanction in paragraph 73 and to the NMC's response. It gave careful consideration to these comments. However, the panel concluded that, in the wider context, with appropriate professional oversight for her level of experience, there is no reason that Miss Wells cannot safely return to practise without conditions of practice being placed on her registration.

The panel therefore concluded that no useful purpose would be served by a conditions of practice order. It is not necessary to protect the public and would not assist Miss Wells' return to midwifery practice.

The panel agreed with the CPD that a caution order would adequately protect the public. For the next two years, Miss Wells' employer - or any prospective employer - will be on notice that her fitness to practise had been found to be impaired and that her practice is subject to a restriction. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of two years would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered midwife.

At the end of this period, the note on Miss Wells' entry in the register will be removed. However, the NMC will keep a record of the panel's finding that her fitness to practise had been found impaired. If the NMC receives a further allegation that Miss Wells' fitness to practise is impaired, the record of this panel's finding and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to Miss Wells in writing.

That concludes this determination.