Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
7 – 10 February and 11 March 2022
Nursing and Midwifery Council
Virtual Hearing

Name of registrant:	Miranda Egelstaff
NMC PIN:	73Y1341E
Part(s) of the register:	Registered Nurse – Sub Part 2 Adult Nursing – April 1975 Registered Nurse – Sub Part 1 Adult Nursing – August 2001
Area of registered address:	Conwy
Type of case:	Misconduct
Panel members:	Yvonne O'Connor (Chair, registrant member) Alexandra Hawkins-Drew (Registrant member) Richard Bayly (Lay member)
Legal Assessor:	7 – 10 February 2022: Patricia Crossin 11 March 2022: Marian Gilmore
Hearing Co-ordinator:	Ruth Bass
Nursing and Midwifery Council:	Represented by Yvonne Ferns, Counsel instructed by the NMC
Ms Egelstaff:	Present and represented by Libby Anderson, Counsel instructed by Thompsons Solicitors
Facts proved by way of admission:	**1, 4, 5 and 6**
Facts found proved:	**2, 3 and 7**
Facts not proved:	**None**
Fitness to practise:	**Impaired**
Sanction:	**Voluntary Removal Granted by the Registrar**
Interim order:	**N/A**

Decision and reasons on application to amend the charge

At the start of the hearing an application was made by Ms Ferns, on behalf of the NMC, to amend the charges by removing the initials of any residents which had been included. Ms Ferns submitted that the removal of the initials was necessary to preserve the anonymity of the residents. She submitted that the residents were already anonymised and as such could be identified for the purposes of this hearing whilst remaining anonymous.

Ms Ferns further submitted that the amendments were required as a result of an administrative error and that no prejudice or injustice would be caused to you as a result of the amendments being granted. The application was made under Rule 28 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Anderson, on your behalf, did not contest the application. She agreed with the submissions made by Ms Ferns and submitted that the amendments would not affect the case.

The panel accepted the advice of the legal assessor that Rule 28 states:

> *'**28.—** (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—*
>
> *(a) the charge set out in the notice of hearing; or*
>
> *(b) the facts set out in the charge, on which the allegation is based,*

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.'

The panel considered the amendments sought to be minor in nature, and noted that both parties were in agreement. It was of the view that the amendments were necessary to maintain the privacy of the residents. The panel was satisfied that there would be no prejudice to you and that no injustice would be caused to either party by the proposed amendments being allowed. It determined that it was appropriate to allow the amendments as applied for, and remove any initials identifying the residents.

Details of charge as amended

That you, a registered nurse:

1) On 18 October 2018 applied a normal adhesive dressing to Resident A, when their care plan required that an Aquacell dressing be used.

2) On 25 October 2018 did not administer and/or record contemporaneously that you had administered:
a) Co-careldopa to Resident B at 12:00 as prescribed
b) Ensure to Resident B at 12:00 as prescribed
c) Adcal-D3 to Resident C at 14:00 as prescribed
d) Aspirin to Resident D at 12:00 as prescribed
e) Paracetamol to Resident D at 12:00 as prescribed
f) Paracetamol to Resident E at 12:00 as prescribed
g) Rivaroxaban to Resident E at 12:00 as prescribed
h) Salbutamol to Resident F at 12:00 as prescribed
i) Aspirin to Resident F at 12:00 as prescribed

3) On 1 November 2018, did not record any information about GP visits in relation to up to six unknown residents, including:
a) Resident G
b) Resident H
c) Resident I
4) On 2 November 2018 did not administer phenytoin sodium to Resident J at 18:00 as prescribed.

5) On 2 November 2018 did not administer and/or record that you had administered phenytoin sodium to Resident K at 18:00 as prescribed.

6) On 13 November 2018, did not administer amoxicillin to Resident L at 12:00 as prescribed.

7) On 13 November 2018, at around 13:50, allowed Resident L to lie flat on their back when they should have been sat upright.

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

Decision and reasons on applications for Ms Egelstaff to keep her camera off during the hearing and for sections of the hearing to be held in private

Ms Anderson made a request for you to be able to keep your camera off during these proceedings. She submitted that [PRIVATE], would be more comfortable with the camera off and would notify her by text message if you were to experience any technical issues.

Ms Anderson also made an application for parts of this hearing, pertaining to your health, to be held in private. The application was made pursuant to Rule 19 of the Rules.

Ms Ferns expressed that she had no objection to your camera being off, providing you are able to communicate as necessary should you have any issues.

With regard to the Rule 19 application Ms Ferns agreed that it was proper that matters relating to your health were heard in private.

The panel accepted the advice of the legal assessor.

With regard to your camera being off, the legal assessor advised that the panel should take into account the fairness to the proceedings in this regard.

With regard to the Rule 19 application, the legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined, with regard to the application for you to have your camera off throughout these proceedings, to allow the application in order for you to be able to participate more comfortably in the hearing. The panel was made aware that your daughter would be present with you to provide support.

With regard to the application under Rule 19, having heard that there will be reference to your health, the panel determined to hold such parts of the hearing in private.

Facts

At the outset of the hearing, the panel heard from Ms Anderson, who informed the panel that you made full admissions to charges 1, 4, 5 and 6.

The panel therefore found charges 1, 4, 5 and 6 proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Ferns and Ms Anderson.

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

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

- Ms 1: Deputy Manager of Cartref Bryn yr Eglwys Care Home at the time of the alleged incidents;

- Ms 2: Manager of Cartref Bryn yr Eglwys Care Home at the time of the alleged incidents.

The panel received a written submission with attached documents on your behalf.

Background

The charges arose whilst you were contracted as a registered nurse to Cartref Bryn yr Eglwys Care Home (the Home) by Health Recruitment Network (the Agency). You worked at the Home from 2 October 2018 until 14 November 2018. The Home is described as a care home for adults with general healthcare needs, the majority of whom are elderly, with 20 beds spread over 2 floors. On a day shift there is usually 1 registered nurse and 3 carers on duty and on a night shift, 1 registered nurse and 1 carer.

Ms 1 was the Deputy Manager of the Home at the time of the alleged incidents. As part of her role, Ms 1 also conducted nursing shifts at the Home and received handovers

from you. It is alleged that on 18 October 2018 Ms 1 noted that you had not applied Aquacell dressing to Resident A. It is further alleged that Ms 1 noticed that you had not administered medication or not completed five residents' Medication Administration Records (MAR) charts on 25 October 2018, and also noticed that you had not recorded any information about the General Practitioner's (GP's) weekly check-ups in relation to several residents on 1 November 2018.

Ms 2 was the Manager of the Home at the time of the alleged incidents. Ms 2 was made aware by Ms 1 of concerns regarding your clinical practice in wound care, medical administration and record keeping and the care for a patient with a chest infection. On 2 November 2018, Ms 2 became aware that you had not administered medication to a number of residents. Ms 2 held a meeting with you on 8 November 2018 to raise these issues. It is alleged that on 13 November 2018, you had not administered antibiotics to Resident L and had allowed Resident L, who had a chest infection, to lie flat when they should have been sat upright to prevent shortness of breath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the oral and documentary evidence from Ms 1 and Ms 2, and documentary evidence provided by both Ms Ferns and Ms Anderson. The panel drew no adverse inference from you not giving oral evidence.

Charge 2

On 25 October 2018 did not administer and/or record contemporaneously that you had administered:
a) Co-careldopa to Resident B at 12:00 as prescribed
b) Ensure to Resident B at 12:00 as prescribed
c) Adcal-D3 to Resident C at 14:00 as prescribed
d) Aspirin to Resident D at 12:00 as prescribed
e) Paracetamol to Resident D at 12:00 as prescribed
f) Paracetamol to Resident E at 12:00 as prescribed
g) Rivaroxaban to Resident E at 12:00 as prescribed
h) Salbutamol to Resident F at 12:00 as prescribed

i) Aspirin to Resident F at 12:00 as prescribed

These charges are found proved in relation to the recording of medication contemporaneously.

In reaching this decision the panel considered the MAR charts for Residents B,C, D, E and F, for 25 October 2018, and noted that all of the entries listed in the charges contained the initials *'ME'* and were circled. It heard evidence from Ms 1 that she had noted blank boxes on the MAR chart where a signature was required to confirm that the medication had been given. In the event that the medication had not been given, an identified code should have been entered to confirm the reason for the omission. Ms 1 circled these blank boxes to identify where the signatures were missing. Ms 1 told the panel that you later initialled the missing entries following her raising concerns about the lack of recording with you. The panel could see from the MAR charts of the respective residents that the relevant entries had been circled.

The panel also considered your written submission dated 4 February 2022 and noted your comments as follows:

> *'A MAR Chart should be countersigned by the Deputy Manager for that day. I therefore do not understand why there are no records to account for what medication the residents listed at a) to i) above were administered. There should have been two signatures on this MAR Chart – mine and [Ms 1's].*
>
> *…If this was the case, I am surprised that [Ms 1] did not contact me straight away as soon as this was identified as I only live 6 miles away and could have returned to rectify the situation.'*

The panel noted that you had acknowledged that you should have signed the MAR charts for the relevant entries, but went on to state that the entries should have been countersigned by Ms 1. It concluded that you had, in essence, admitted that you had not signed the MAR chart and you were of the view that as you were still in a period of induction at the Home, you believed you should have had your work countersigned.

The panel heard evidence from both Ms 1 and Ms 2 that there was no need for your work to be countersigned and that there was no practice of countersigning at the Home. The panel accepted that the period of induction was for the purposes of familiarising yourself with the work environment and Home practice, and this did not prevent an experienced nurse from being able to undertake a medication round without direct supervision.

The panel also had regard to the letter from Ms 1 to you dated 26 October 2018 which states:

> *'I have noticed yesterday, 25/10/18, whilst doing the supper time medication that quite a few of the residents' 1200 medication was not signed on the MAR chart…I'm not sure if their medication was administered and MAR charts not signed or that it wasn't administered at all due to being interrupted by the GP's visit.*
>
> *This is a kind reminder that you need to be more vigilant when administering medication and that as discussed on Thursday, you need to be able to multitask.'*

The panel acknowledged that this was a contemporaneous document, dated the day after the incident alleging that you had not signed the MAR charts of the residents in question. In addition it was clear to the panel that, from this letter, Ms 1 was unsure as to whether you had administered the medication to these residents.

Taking all the evidence into account the panel was satisfied on the balance of probabilities that the residents MAR chart records as itemised in Charge 2, had not been signed by you during the medication rounds on 25 October 2018. The panel was of the view that a qualified registered nurse would be expected to undertake a medication round independently, and would be expected to make appropriate contemporaneous records confirming that the medication had been given or the reason for any omission.

Based on the reasoning set out above, the panel found Charge 2 proved on the basis that you did not record contemporaneously that you had administered the relevant medication.

Charge 3

> *On 1 November 2018, did not record any information about GP visits in relation to up to six unknown residents, including:*
> *a) Resident G*
> *b) Resident H*
> *c) Resident I*

This charge is found proved in its entirety.

In reaching this decision, the panel had regard to the staff rota and noted that you were on duty on 1 November 2018 from 08:00 – 20:00 and that Ms 2 was on duty from 09:00 – 15:00. The panel was told that you and Ms 2 were the only nurses working on the day shift that day.

The panel heard evidence from Ms 1 and Ms 2 that the normal staffing levels for a day shift was 1 registered nurse and 4 unregistered carers. Ms 2 also clarified that although she was a registered nurse and her name was on the rota 5 days a week, Monday – Friday, her role was supernumerary and not included in the nursing staffing levels.

The panel heard evidence from both Ms 1 and Ms 2 that you were the nurse in charge on 1 November 2018 and responsible for accompanying the GP on that visit on that day. The panel heard that GP visits usually took place weekly, on a Thursday.

The panel had regard to your written submission and noted the following comments:

> *'65. On the date in question, 1 November 2018, [Ms 2] attended the doctor's round and it was therefore not my responsibility to record information about the GP visit on this day. It would have been for [Ms 2] to record.*

66. I know for certain that [Ms 2] carried out the GP round on this date as I went over to speak to [Ms 2] to explain to her that I was aware that the tissue viability nurse was coming on the Monday, the following week. I told [Ms 2] this as I saw her coming out of [a resident's] (patient with pressure sore) room with the GP and thought this information would help them both.'

The panel noted that there was no documentary evidence to support this assertion. However, it heard evidence from Ms 1 stating that she had reviewed all the residents' notes so she could have sight of any changes in care plans as she was not on duty on 1 November 2018. Ms 1 stated that she had seen that you had documented the GP visit in 2 sets of resident notes, but not in the notes of the other 6 residents seen by the GP that day.

The panel also had regard to the evidence of Ms 2, who denied undertaking the GP visit on 1 November 2018 and did not recall that you came to her with any issues as mentioned in your written submission. Ms 2 told the panel that you were the nurse in charge that day. The panel noted that you and Ms 2 gave conflicting evidence in this regard. It therefore went on to consider what other evidence had been presented in respect of this charge.

The panel had regard to Ms 1's evidence that confirmed you had undertaken a GP round the previous week as part of your induction with Ms 1. This was confirmed from your written submission that you recalled undertaking a GP round with Ms 1. The panel therefore accepted that you had completed your induction in relation to this. It accepted the evidence that you were the nurse in charge on 1 November 2018 and noted the evidence that you had documented, in respect of 2 residents, the outcome of the GP visits carried out on 1 November 2018.

The panel had regard to the evidence of Ms 1 when she stated as follows:

'On 1 November 2018 a GP came to visit the home to do weekly check-ups. A couple of days after the GP visit I wanted to check the files to see what the GP had said about each of the residents. The GP had seen eight residents and for six of them, the Registrant had not recorded anything.'

The panel was of the view that it was reasonable for Ms 1 to review the residents' files, and to bring to the attention of the Manager (Ms 2) that the GP visits for some residents had not been recorded.

The panel also had regard to the letter dated 6 November 2018 sent to you by Ms 1 setting out her concerns regarding your record keeping, amongst other things. It noted the following:

> **Record Keeping**
> *'On the 1st of November a total number of 8 residents have either being (sic) seen by the visiting GP or there was a conversation regarding their condition or blood results. For 6 of them, there is no record in their notes of GP's visits, discussion and recommendations…'*

The panel also had regard to the meeting notes dated 8 November 2018, of the meeting that took place on 6 November with you and Ms 2. It noted the following:

> *'Another Registered Nurse would now be responsible for completing the 'Doctor's weekly' round – since none of the resident's notes had been updated accurately the previous week by ME. Continued supervision by another Registered Nurse would also not be possible in the long term. [Ms 2] explained that continued medication errors would now result in disciplinary action and NMC referrals being made for incompetency as a way to safeguard the residents, since the Care Home had a duty of care to highlight bad practices to the governing bodies.'*

The panel concluded from all of the evidence presented, that on the balance of probabilities it was more likely than not, you were responsible for accompanying the GP on the visit on 1 November 2018, and did not record any information relating to 6 residents. It therefore found charge 3 proved in its entirety.

Charge 7

On 13 November 2018, at around 13:50, allowed Resident L to lie flat on their back when they should have been sat upright.

This charge is found proved.

In reaching this decision, the panel had regard to your written submission dated 4 February 2022 and noted the following:

'90. This resident was under palliative care and was at end of life. She was sleeping and had Cheyne-Stokes breathing (gasping) with long periods of apnoea. As such I did not feel it was appropriate to sit the patient up fully and put excessive pressure on her diaphragm.

91. At the time I recall thinking that it would be dangerous for me to give the antibiotics medication to the resident for fear of aspiration.'

The panel also had regard to the '*Significant Event'* note dated 13 November 2018 which states:

'…Antibiotics had been prescribed four times per day for resident but at 13:15 was found not to have received her 12md dose. When questioned, ME stated that resident was 'sleeping' therefore she hadn't given her the oral medication which was prescribed for 12 md.'

In addition to the *'Significant Event'* note, Ms 2 gave evidence that Resident L was on anti-biotics, and that a patient on a palliative pathway, at the end of life, would not have had a prescription for anti-biotics. Ms 2 stated that the Home did provide palliative care and had the appropriate pathways in place to support this. Ms 2 told the panel that it would not be the role of a registered nurse to move a resident over to a palliative pathway and that such decisions required a multi-disciplinary team which would include the GP and the residents' relatives. The panel found Ms 2's evidence to be compelling in this regard.

Ms 2 also gave evidence that when she entered Resident L's room on 13 November 2018, she found Resident L lying flat on the bed with 1 pillow and that there were no signs of Cheyne Stoke breathing or apnoea as suggested by you. She told the panel that '*Resident L had a chest infection and therefore should have been sat upright to prevent shortness of breath'*.

You stated in your written submission that Resident L was *'receiving palliative end of life care meaning they were heavily sedated'*. However the panel noted from the care chart for Resident L that approximately 10 mins later, at 2pm Resident L is recorded as having been *'changed and bought* (sic) *to sit in the lounge'.*

The panel also had regard to the *'Care evaluation and progress report'* for Resident L on 13 November 2018 and noted your record as follows:

> *'…No new concerns, at present up in Dining Room'*

The panel noted from this entry that you had not made any comments to the effect that Resident L had experienced apnoea or was displaying signs of Cheyne Stoke breathing earlier that day.

Having considered all of the above evidence, the panel could not accept your description that Resident L was receiving palliative care, was Cheyne Stoke breathing and/or suffering periods of apnoea. It was of the view that on the balance of probabilities, it was more likely than not that Resident L was lying flat on their back when they should have been sat upright. The panel therefore found charge 7 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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

Ms Ferns identified the specific, relevant standards where your actions amounted to misconduct. She submitted that your actions were serious and, individually and collectively, fell seriously short of the conduct of a registered nurse and amounted to misconduct.

Ms Anderson informed the panel that you do not accept misconduct. She submitted that the facts found proved did not amount to misconduct and, at its highest, amounted to negligence or poor judgment against the background of a very busy role with a large number of competing demands on your time whilst at work. Ms Anderson submitted that mere negligence did not amount to misconduct, and that the facts needed to not merely

fall below the standards expected of a registered nurse but ‘far below’. She made reference to the case of Nandi v GMC, and submitted that your actions were not so far below the standards expected of a nurse to be considered deplorable. She submitted that misconduct should not be viewed as anything less than '*serious professional misconduct’* as per the case of *Meadow v. General Medical Council* [2007] 1 All ER 1, and requested that the panel consider each fact in isolation when considering misconduct, and not form a view by considering the facts found proved in totality.

Submissions on impairment

With regard to impairment, Ms Ferns addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). Ms Ferns submitted that limbs a, b and c, set out in the case of Grant, were engaged.

Ms Ferns submitted that, in the absence of any remediation or evidence of current safe practice, there remains a risk to the health, safety and wellbeing of the public should you be allowed to return to unrestricted practice.

Ms Ferns pointed out that you have engaged with the NMC, and submitted that you have demonstrated some insight by way of your acceptance to some of the charges, but deny that your fitness to practise is currently impaired by reason of your misconduct in all the charges. Ms Ferns referred the panel to the case of Cohen v GMC [2007] EWHC 581 (Admin), and submitted that the regulatory concerns in this case are capable of remediation by way of satisfactory performance in the identified areas of concern. Ms Ferns submitted that you have not provided any evidence of remediation. However, she stated that it was a matter for the panel to determine whether your conduct has been remedied.

Ms Ferns submitted that your fitness to practise is currently impaired, on the grounds of public protection and the wider public interest. She submitted that your failings relate to core nursing requirements of basic nursing skills and that a finding of current impairment is necessary to declare and uphold proper standards. She further submitted that your actions were so serious, that a finding of current impairment is required in order to maintain public confidence in the profession and the NMC and to uphold proper professional standards. The public confidence in the profession and the NMC as regulator would be undermined if that behaviour was allowed to pass effectively unmarked.

Ms Anderson informed the panel that you did not accept that your fitness to practise is impaired. She submitted that you are not currently impaired on either ground.

Regarding the public interest, Ms Anderson submitted that the charges were not so serious that they would bring the nursing profession into disrepute, as the public were likely to understand the pressures that nurses work under and have a tolerance for a degree of human error. She further submitted that you have demonstrated insight by way of admitting some of the charges, and reflecting on all charges in your submissions considering the impact on the residents, the wider profession and the team at the Home. Ms Ferns submitted that you have expressed remorse for the incorrect judgments made and apologised to the residents and their families. She told the panel that you had explained why record keeping is so important in your written submission, explained why it is so important to give medication at the appropriate time and to communicate the same.

Ms Anderson submitted that you had been working well in hospital settings since leaving employment at the Home and have demonstrated remediation. She told the panel that pre COVID - 19 you had been working in a hospital until being deemed vulnerable due to your age. She told the panel that you had worked on Aberconwy Ward for a year and referred the panel to a reference which, although did not explicitly say so, was written in the knowledge of these allegations.

Ms Anderson submitted that you had completed a wide variety of CPD training in the intervening period since 2018 and had received very high scores in infection control, dementia awareness, aseptic non touch technique, and use of nan-endoscopes. She submitted that the charges appeared out of character for you and that there had been no further issues since 2018 whilst working as a registered nurse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: Cohen, Mallon v NMC 2007, Roylance, Meadows, Grant, 5th Shipman Report, and Cheatle v GMC 2009.

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse in respect of charges 2, 4, 5, and 6, and that your actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

To achieve this, 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

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

To achieve this, you must:

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

6 Always practise in line with the best available evidence
To achieve this, you must:

6.1 make sure that any information or advice given is evidence based including information relating to using any health and care products or services

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

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:

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

13 Recognise and work within the limits of your competence

The panel first considered the charges individually and made the following findings:

Charge 1 – not misconduct

The panel had regard to the fact that you had placed a dressing on a resident that was inappropriate. It acknowledged the pain that would have been caused to the resident as a result of your actions. The panel also had regard to the evidence that you had effectively put the incorrect dressing on to reduce the risk of infection whilst attempting to locate the correct dressing. This was a resident who suffered from incontinence, and leaving the wound uncovered could have resulted in an increased risk of infection.

While the panel considered your actions in placing the incorrect dressing on the resident amounted to poor practice under unfortunate circumstances, it was of the view that you had taken the residents needs into consideration by ensuring the wound was not contaminated while the correct dressing was located. It had regard to the fact that you

immediately reported the matter to Ms 1 at the handover and had taken into account, before applying the dressing, that the resident would need pain relief in any event prior to the dressing being changed. It was of the view that you had taken the decision to dress the wound with an inappropriate dressing to ensure the wound was covered until the correct dressing could be applied.

The panel was of the view that although your actions amounted to poor practice, it did not meet the high bar required for serious misconduct.

Charge 2 - misconduct

The panel was of the view that your actions in regard to charge 2 did amount to misconduct. By not recording that you had administered medication on the residents MAR charts, you placed the residents at a risk of harm as your colleagues would not have known if the medication had been given, and could have unknowingly given the residents the medication twice. If not administered this could have resulted in residents being placed at risk due to prescribed medication not being administered as part of their treatment of care.

The panel also had regard to the fact that there were 9 drugs that were not signed for and which affected 5 patients.

The panel had regard to your written submissions and noted your comments that someone else should have countersigned the medication, and you did not accept that it was your responsibility as a registered nurse to record that you had administered the medication. You maintained that in the event of not signing the MAR charts, someone else should have countersigned the charts, despite the responsibility of completing the documentation being yours. The panel was of the view that you had failed to understand your own failings and then deflected blame onto a colleague. You did not take any accountability for your actions, and have not expressed any concern for the residents with regard to what could have happened. The panel was therefore satisfied that the range and number of issues in relation to this charge made it capable of reaching the high bar for misconduct. It considered sections 1.2, 1.4 and 10.1 of the Code relevant in its decision making.

Charge 3 – not misconduct

The panel was of the view that your failings with regard to charge 3 did not meet the high bar required for misconduct. It acknowledged that reviews of residents care and conditions by a GP should have been documented and made available to the rest of the team. However it had not heard any evidence from the NMC that residents were placed at risk, or that there had been any harm to patients as a result of these omissions. In the absence of such information, the panel considered this to be a relatively low risk clinical situation in that the GP visits were organised as part of a regular weekly routine visit. The panel was of the view that your actions did amount to poor practice, but in the absence of such evidence, did not amount to misconduct.

Charge 4 – misconduct

The panel was of the view that your actions in regard to charge 4 did amount to misconduct.

The panel had regard to the fact that phenytoin sodium is an extremely important anti-epileptic medication, with significant risks if it is not given as prescribed. As a registered nurse, you should have been aware of the risk of harm to the resident if the medication was not given, but instead you decided not to wake the resident to give them this medication. This was an important drug for a specific condition, and by not administering it, the resident was placed at risk of possibly suffering a seizure.

The panel was of the view that it was wholly inappropriate not to administer a prescribed drug because a patient was asleep. There were other actions that could have been taken by you, which you acknowledged in your written submissions and you also acknowledged on reflection that you should have woken the resident. The panel therefore found that your actions in relation to charge 4 did amount to misconduct, and that sections 1.2, 1.4, 3.1, 6.1 and 6.2 of the Code were relevant.

Charge 5 – misconduct

The panel was of the view that your actions with regard to charge 5 did amount to misconduct. By not signing the MAR chart to evidence that the phenytoin sodium had been given to the resident, you placed the resident at a risk of harm, as your colleagues would not have known if the medication had been administered or not. Furthermore the panel noted some of your reasons given for not recording whether the medication had been given to include that the Home was busy, you could not identify some of the residents, and you were interrupted often when undertaking the medication round. However there was no evidence to confirm what actions you had taken in light of the issues you had identified. As described in charge 4, phenytoin sodium is an extremely important medication that if not administered as prescribed could have placed the resident at a risk of harm. The panel considered sections 1.2, 1.4, 3.1, 6.1, 6.2 and 10.1 of the Code were relevant to its findings.

Charge 6 – misconduct

The panel was of the view that your actions with regard to charge 6 did amount to misconduct. This was a deliberate omission of prescribed medication by you, for the reason that the patient was asleep. Prescribed medication is required to be given at a specific times for a specific reason, and by not administering the medication you placed the resident at a risk of harm. In this case, the resident had a chest infection and you decided not to give the antibiotic medication that was prescribed for an unwell and vulnerable resident without seeking the advice from a senior member of staff or colleague. You stated that you did not give the antibiotic to the resident because you believed them to be apnoeic and receiving end of life care. The evidence presented to the panel indicated that this was not the case (as set out in its decision on the facts). Your decision not to administer the antibiotic to Resident L was outside of your scope of practice, and compounded by the fact that you came to the wrong conclusion concerning the resident's health and condition at the time. The panel determined that it was inappropriate for you to make decisions as to whether prescribed medication should be administered without consulting with the senior member of staff. The panel found sections 1.2, 1.4, 3.1, 6.1, 6.2 and 13 of the Code were relevant to its findings.

Charge 7 – not misconduct

The panel was of the view that your actions with regard to charge 7 did not amount to misconduct.

There was insufficient evidence before the panel to suggest that the resident was seriously ill at the time. Further, the panel was of the view that whilst being encouraged to sit up as part of the management of a patient with a chest infection is good practice, there was no evidence presented to the panel to suggest that not being sat up presented a significant risk to the resident's health. The panel also noted that very shortly after this incident the resident was assessed and sat up. Further the nursing documentation recorded that within a short period of time the resident was in the day room and no new concerns were noted. The evidence before the panel was that the resident had been repositioned and had had their pad changed. The panel was therefore of the view that this resident was not seriously unwell. It concluded that whilst it would have been good practice to encourage the patient to sit up, there was no evidence that it caused significant harm or discomfort to the resident in allowing them to lie flat.

Overall the panel concluded that this was not an isolated incident. The panel identified that there was a pattern of serious omissions and poor practice in relation to a range of nursing duties. Overall there were serious errors in relation to the poor assessment of patients, medication administration and record keeping, and a failure to consider the risks associated with some of your decisions. These errors and omissions happened on several occasions over a period of several weeks. The panel therefore found that in considering charges 2, 4, 5, and 6 in totality, your actions and omissions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *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.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

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

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

The panel finds that residents were put at risk of harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel found that you had limited insight into your misconduct, including the charges that had been admitted by you. It had regard to your written submissions and noted that you had made numerous apologies. However, the panel noted with regard to the charges relating to record keeping and the non-administration of medication, that you did not acknowledge the impact your failings could have had on residents. The panel also had regard to your submissions where you had attempted to blame others for some of your failings. The panel noted that you expected your colleague to countersign your medication administration, and expressed that mistakes were made due to residents not wearing name bands and records not containing up to date photographs. However, there was no evidence that you had raised these concerns or had attempted to address them. Furthermore the panel was very concerned by your lack of insight around the implications of your actions on Resident L when you decided not to administer prescribed antibiotics for their chest infection.

The panel also had regard to the fact that you had provided certificates for a number of courses, none of which appeared to relate to the areas of concern. The panel was informed that you had undertaken courses in relation to the administration of medication and record keeping and had received 100%. However, you did not provide evidence of this to the panel. The panel therefore determined that your insight was limited at this stage.

The panel did take into account how difficult you found it working at the Home, and the strained relationship you described with your colleagues. However it was of the view that you are an experienced nurse and such fundamental breaches of tenets should not have occurred in any event.

The panel was satisfied that the misconduct in this case is capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not you have remedied your practice. The panel took into account the reference provided. Whilst it was submitted by Ms Anderson that the maker of the reference was aware of these proceedings, the panel had no evidence of this.

The panel was told that since leaving the Home you had conducted roughly 200 shifts as a bank nurse on a hospital ward. The panel noted that you had not provided any evidence to show what you had been doing, that you had strengthened your practice in the areas of concern, or provided any references from your colleagues. With regard to the training certificates provided by you, the panel was of the view that the training was not relevant. The panel acknowledged your assertion that you would not repeat your mistakes, however, you failed to demonstrate what you would put in place or do differently in the future. The panel is therefore of the view that there is a significant risk of repetition. It therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel determined that a finding of impairment on public interest grounds is required. It was of the view that members of the public would be concerned if a registered nurse did not record the administration of medication, or administer medication that patients should be receiving. It was of the view that there would be would be a loss of public confidence in the profession if you were allowed to practise without restriction. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Decision and reasons on application for the voluntary removal application to be heard wholly in private

Ms Anderson made an application for a voluntary removal application to be heard in private, on the basis that it contained details relating to Ms Egelstaff's health, personal and financial circumstances which could not be separated from the application. The application was made pursuant to Rule 19 of the Rules.

Ms Ferns did not oppose the application.

The panel accepted the advice of the legal assessor in respect of Rule 19.

Having heard that there will be matters of Mr Egelstaff's health, personal and financial circumstances which are inextricably linked to a voluntary removal application, the panel determined to hold the voluntary removal application wholly in private.

Voluntary Removal application and Recommendation

Following the announcement of the panel's findings on impairment, Ms Anderson made an application for voluntary removal on behalf of Ms Egelstaff. She provided the panel with a copy of this application and the supporting documentation.

[PRIVATE]

In all the circumstances, the panel was of the view that both public interest and public protection would be adequately served by the granting of this application. The panel therefore recommends that the Registrar accept Ms Egelstaff's application for Voluntary Removal.

Voluntary Removal Agreed

The panel noted that the application for voluntary removal was accepted by the Assistant Registrar of the NMC on 11 March 2022. This decision was announced by the Chair of the panel on 11 March 2022.

The panel therefore has no jurisdiction to deal with this matter further.

This will be confirmed to Ms Egelstaff in writing.

That concludes this hearing.