Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 03 May 2022 –
Friday, 27 May 2022

Virtual Hearing

Name of registrant:	**Nino Yraola**
NMC PIN:	15D0059O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nurse – April 2015
Relevant Location:	Cheshire East
Type of case:	Lack of Competence and Misconduct
Panel members:	Melissa D'Mello (Chair, Lay member) Sharon Peat (Registrant member) Alex Forsyth (Lay member)
Legal Assessor:	Robin Hay
Hearings Coordinator:	Xenia Menzl
Nursing and Midwifery Council:	Represented by Alfred Underwood, of Counsel, Case Presenter
Mr Yraola:	Present and represented by Leslie Knibbs (3 – 20 May 2022) Antonino Gamboa (23 – 27 May 2022)
Facts proved:	Charges 1, 2, 3ii), 5iii), 6, 7i), 7ii), 7iii), 7v), 7vi), 8, 10i), 10ii), 12v), 14i), 14ii), 16i), 16ii), 16iii)a), 16iii)b), 17, 18, 19i), 19ii), 19iii)
Facts proved by admission:	Charges 3i), 5i), 7iv), 9, 11, 12i), 12ii), 12iii), 13, 15
Facts not proved:	Charges 4, 5ii), 12iv),

Fitness to practise:	Impaired
Sanction:	Suspension Order, 12 Months with review
Interim order:	Interim Suspension Order, 18 Months

Decision and reasons on application for parts of the hearing to be held in private

At the outset of the hearing, Mr Underwood, on behalf of the Nursing and Midwifery Council (NMC), made an application that parts of this hearing be held in private on the basis that proper exploration of your case involves reference to the health and personal circumstances of some of the witnesses and you. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Knibbs, on your behalf, supported the application.

The panel accepted the advice of the legal assessor.

The panel determined that references to the health and personal circumstances of witnesses and you should be heard in private.

Decision and reasons on application to admit hearsay evidence

Mr Underwood made an application under Rule 31 that the panel should admit in evidence the witness statement of Colleague H. This related to charges 1, 3 and 7. He said that the witness had been warned well in advance of the hearing and had confirmed her attendance. However, unforeseen, extenuating personal circumstances, as a result of which she would be unable to attend, had arisen only on about 9 May 2022, during the second week of the hearing.

Mr Underwood said that evidence in relation to said charges would be given by Colleague A, Colleague C and Colleague F and therefore that of Colleague H was not the sole and decisive evidence. Further, there is nothing to indicate that Colleague H had any reason to fabricate her evidence.

Mr Underwood said that charges 1, 3 and 7 relate to the lack of competence allegation and are part of a wider pattern of behaviour which is reflected by 16 other charges. He submitted that these three charges are not more significantly serious than the others.

Mr Underwood submitted that when this change in Colleague H's circumstances became known, the NMC had acted with due expedition in informing Mr Knibbs, on 10 May 2022, of this event and of this application.

Mr Underwood said that although this evidence could not now be tested in cross examination, any unfairness that might arise can be addressed by the panel attaching to it the appropriate weight.

Mr Underwood's submission was that this application satisfies the requirements of Rule 31 as the evidence is clearly relevant and its admission would not result in unfairness to you.

Mr Knibbs accepted that there was a good reason for the non-attendance of the witness, but his submission was that as her evidence could not be tested before the panel it would be unfair if it were admitted.

In reaching its decision, the panel considered all the information before it together with the submissions made by Mr Underwood and Mr Knibbs. It had well in mind the appropriate matters to take into account when exercising this balancing exercise, to which helpful reference is made in the case of *Thorneycroft v NMC* [2014] EWHC 1565 Admin.
The panel accepted the advice of the legal assessor.

The panel was satisfied that Colleague H's witness statement was not the sole and decisive evidence in support of these three charges. Moreover, there seemed to be an acceptance in part to charge 1. The panel therefore determined that this evidence was relevant to charges 1, 3 and 7 and that although it could not be tested before the panel, any resulting unfairness to you could be addressed by taking this into account when attaching to it what it deemed to be the appropriate weight.

The panel therefore allowed the application and admitted into evidence Colleague H's witness statement.

Decision and reasons on application to amend the charge

Mr Underwood made an application under Rule 28 to amend the wording of charge 14. He said that the current charge refers to 28 August 2018 although it is clear from the evidence that the failings mentioned in the sub charges occurred on the 22 August 2018. He submitted that this was a typographical error and that amending the relevant date to 22 August 2018 would more accurately reflect the evidence and would not affect the substance of the allegation.

Original Charge:

14. On 28 August 2018

Amended Charge:

14. On ~~28~~ **22** August 2018

Mr Knibbs did not oppose the application.

The panel considered all the information before it together with the submissions of Mr Underwood and Mr Knibbs. It accepted the advice of the legal assessor.

The panel was satisfied that the proposed amendment was by way of clarification and that no injustice to you would arise. It therefore allowed the application.

Details of charge (as amended)

That you, whilst employed as a Band 5 Staff Nurse at Macclesfield District General Hospital between 06 November 2017 and 31 July 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision in that you

1. On unknown dates between 01 December 2017 and 01 April 2018 shouted 'garlic' at one or more colleagues **[proved]**

2. On an unknown date before 21 January 2018, when inserting a Nasogastric ('NG') tube, did not take appropriate steps when the patient was in discomfort **[proved]**

3. On 21 January 2018, left Ward 3
   i) Staffed with only one other registered nurse (Colleague A) on the Ward and/or **[proved by admission]**
   ii) Did not inform Colleague A that you were leaving the Ward **[proved]**

4. Around April 2018, on one or more occasion, raised your voice to a colleague who was addressing you in your professional capacity **[not proved]**

5. On 20 April 2018, in relation to Patient H, despite their deteriorating condition;
   i) Reduced monitoring from 4 hourly to 8 hour and/or **[proved by admission]**
   ii) Did not refer the patient to the doctor for review and/or **[not proved]**
   iii) When Colleague B asked you about the treatment you provided to Patient H, declined to answer questions **[proved]**

6. On 20 April 2018, in relation to Patient O, despite their deteriorating condition, did not refer the patient to the doctor to review **[proved]**

7. On 23 April 2018
   i) Directed Colleague C to administer medication to Patient H when she it was not appropriate for her to do so and/or **[proved]**
   ii) Stormed over to Patient H and/or **[proved]**
   iii) Threw Patient H's head back and/or **[proved]**
   iv) Tipped more than one medication in to Patient H's mouth and/or **[proved by admission]**
   v) Did not remain with Patient H to supervise her safe digestion of the tablets and/or **[proved]**
   vi) Did not promptly return to Patient H when Colleague C informed you that they were choking **[proved]**

8. On 23 April 2018 did not take prompt action when Colleague C informed you that Patient S had passed loose stools **[proved]**

9. On 23 April 2018 commented loudly that Patient H was 'too heavy for Colleague B to move on her own' or words to that effect **[proved by admission]**

10. On 23 April 2018
   i) Did not take prompt action when Colleague C informed you that Patient M was in pain and/or **[proved]**
   ii) Laughed/scrolled on your mobile phone when Colleague C was providing information to you about patients **[proved]**

11. On 23 April 2018 did not assist Colleague C in summoning emergency help when Patient P had fallen **[proved by admission]**

12. On 20 August 2018

    i) On one or more occasions, did not introduce yourself to patient/s when providing care and/or **[proved by admission]**

    ii) Attempted to mix a powder and a tablet medication in a plastic cup and/or **[proved by admission]**

    iii) Unnecessarily announced to a patient that their medication was for '…mind and depression' and/or **[proved by admission]**

    iv) Unnecessarily woke a patient up to offer paracetamol and/or **[not proved]**

    v) Communicated poorly with a patient about their anti-sickness patch **[proved]**

13. On 21 August 2018, spent an extended time in the toilet during a study day **[proved by admission]**

14. On 22 August 2018

    i) You attempted to give oral medication to a patient when he was too drowsy to take them and/or **[proved]**

    ii) You prematurely attempted to remove a blood pressure cuff and/or observations machine from a patient **[proved]**

15. On 24 August 2018, arrived late to shift **[proved by admission]**

16. On 24 August 2018

    i) On one or more occasions, laughed inappropriately during the medication round and/or **[proved]**

    ii) On one or more occasions, shouted 'open' to a patient following administering medication and/or **[proved]**

    iii) When informed by a Care Support Worker ("CSW") that a patient was suffering chest pain **[proved]**

a) Did not give the CSW an appropriate management plan for the patient and/or**[proved]**
b) Did not escalate the patient to senior nursing and/or medical staff **[proved]**

17. On 06 November 2018, laughed and/or talked to yourself during a medical procedure a doctor was performing on a patient **[proved]**

18. Between the beginning of November 2017 and the end of November 2018, other than on the occasion referred to in Charge 18 above, on one or more occasions, laughed and/or talked to yourself during shift **[proved]**

19. On 09 November 2018
    i) Viewed an image of a naked adult female on your phone in the 'Children's Play Area' and/or **[proved]**
    ii) Confronted Colleague E about a medication error in a public area and/or **[proved]**
    iii) Confronted Colleague E unnecessarily about the medication error as remedial action was already underway **[proved]**

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence save for Charge 19.i where it is impaired by reason of your misconduct.

Background

You began employment as a staff nurse at Macclesfield General Hospital (the Hospital) in November 2017. Previously you had worked for around two years at a care home in the UK. Prior to that you had been a nurse in the Philippines. You worked on Ward 3 at the Hospital before moving to the Outpatients Department in November 2018.

The Hospital first became concerned about your practice early in your employment. It was reported by various staff members that you allegedly often behaved in a strange and often inappropriate manner, particularly for a hospital ward setting. This included allegedly laughing at inappropriate times, talking to yourself when dealing with patients, shouting out comments or random words, like “garlic” at colleagues and speaking to colleagues in an unprofessional way. Staff found this behaviour off-putting and giving rise to stress in the working environment.

Concerns later arose about your clinical practice and your manner with patients in general and at the bedside. Reports were made about your alleged failure to escalate concerns about patients who were deteriorating and poor practice in respect of medication administration. Examples included the allegation that you tipped pills into a patient’s mouth in a rough manner and the allegation that you had not referred to a doctor a patient who was clearly in a deteriorating condition.

The hospital became concerned [PRIVATE] you were suspended from practice from 23 May 2018. You returned to work under supervision for two short periods, August 2018 and November 2018, but on both occasions your suspension was re-instated [PRIVATE].

On 5 November 2018 you started a placement in the Outpatient Department, during which it is alleged you confronted Colleague E, whom you were shadowing, about an error, in front of patients and staff in a loud manner which upset her, so much so that they informed the sister they could no longer work with you. It is further alleged that during this time you viewed, whilst in the children’s play area, an image on your mobile phone of a naked woman, while laughing to yourself.

[PRIVATE]

On 9 April 2019 the Hospital launched a formal disciplinary investigation into your behaviour. On 11 July 2019, a disciplinary hearing was held by the Trust.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Knibbs that you made full admissions to charges 3i), 5i), 7iv), 9, 11, 12i), 12ii), 12iii), 13, 15.

The panel therefore found charges 3i), 5i), 7iv), 9, 11, 12i), 12ii), 12iii), 13, 15 proved in their entirety, by way of your admissions.

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 evidence from the following witnesses called on behalf of the NMC:

- Colleague A: Staff Nurse on Ward 3 at Macclesfield General Hospital;
- Colleague B: Clinical Care Outreach Nurse Practitioner at Macclesfield General Hospital;
- Colleague C: Healthcare Assistant at Macclesfield General Hospital;
- Colleague D: Head of Nursing at Macclesfield General Hospital;
- Colleague E: Enrolled Nurse at Outpatients Department at Macclesfield General Hospital;

- Colleague F: Senior Sister on Ward 3, your direct Manager, at Macclesfield General Hospital;
- Colleague G: Clinical Education Facilitator at Macclesfield General Hospital;
- Colleague I: Staff Nurse on Ward 3 at Macclesfield General Hospital;
- Colleague J: Matron for Medical Specialities at Macclesfield General Hospital;
- Dr 1: Junior Doctor at Macclesfield General Hospital.

You too gave evidence.

In reaching its decisions on the disputed facts, the panel took into account all the evidence before it, both oral and documentary, together with the submissions made by Mr Underwood and by Mr Knibbs.

The panel accepted the advice of the legal assessor.

Before making any findings on the facts, the panel considered Mr Knibbs' submission that there has been some collusion between the witnesses. However, there is before the panel no evidence to support this. During questioning this was raised with some of the witnesses and this assertion was denied. Mr Knibbs further commented that the attitude of some members of staff was such as to amount to bullying. However, in the course of your evidence you said that everyone had been helpful and supportive.

The panel did consider whether either the alleged collusion or bullying could be in relation to cultural or racial issues. In this context the panel referred to the internal investigation report:

> '*The investigation found that purposeful actions had been taken to enable* [Mr Yraola] *to work with a cross section of people from different teams in order to ensure that there was fair and independent assessment without bias or preconceived ideas about* [Mr Yraola]*. This included* [Mr Yraola] *working with a fellow Filipino staff nurse* [Colleague I] *who also reported concerns over professional standards and communications whilst working alongside him, including that a patient has asked her to check their medication as they 'don't trust him'* […]*.*
>
> *The investigation has found that there are repeated accounts of the same concerns and issues arising from this cross section of staff as well as patient/public observations. The investigation found evidence of a random encounter*[…] *by a member of the public expressing concerns over* [Mr Yraola]*'s behaviour during a visit to the hospital. The investigation has found no evidence to indicate that the concerns raised about* [Mr Yraola] *are related to culture or race.*'

The panel therefore concluded that there was no evidence or information to support these submissions by Mr Knibbs that there had been collusion between the witnesses or conduct amounting to bullying.

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

Charge 1

1. On unknown dates between 01 December 2017 and 01 April 2018 shouted ‘garlic’ at one or more colleagues

This charge is found proved.

In reaching this decision, the panel had regard to the evidence of Colleague F and that of Colleague H together with the local investigation report and your evidence.

The panel considered Colleague H’s written evidence in which she states:

> ‘*I recall that the Registrant would often shout the word “garlic” at the Indian nurses on the Ward. Staff Nurse* [1] *and Staff Nurse* [2] *both reported to me that they found that they found it offensive and uncomfortable when the Registrant shouted “garlic” at them as they walked past him, or when they came into his view.*
>
> *I recall that when I witnessed the Registrant shouting this, I asked him why he was doing it, however, the Registrant would respond to say that he was not, or he would simply just laugh, despite me having just heard him say it. The registrant never gave a reason for his behaviour.*’

The panel was conscious that the evidence in relation to Staff Nurses 1 and 2 was hearsay within hearsay and concluded that it would attach little weight to this. However, the panel attached significant weight to the statement of Colleague H, as she was your manager and there was nothing to suggest that she fabricated this allegation.

Further, the description of events was corroborated by similar encounters described by Colleague F who stated that you often asked staff members whether they liked garlic.

In your evidence you said that Indians are known to use a lot of herbs and spices in their cuisine and that you were curious and wanted to discuss this with your Indian colleagues.

When questioned in evidence you initially stated that you had stopped asking colleagues about spices after your manager had asked you to stop. Later, in evidence, you accepted that you continued to try to initiate such discussions even after you had been alerted by Colleague H that this made your colleagues feel uncomfortable. The panel did not accept that this satisfactorily explained why your colleagues felt uncomfortable when you approached them in this manner.

In your evidence you accepted that you used the word “garlic” randomly when speaking to colleagues but you denied shouting it. The panel considered whether you did shout the word or whether you used the word at normal volume when trying to initiate these discussions. In her evidence Colleague H described your using the word when the colleagues walked past or came into your view while working on the ward. The panel concluded that as you were not in conversation with your colleagues at the time, you called out using a loud, raised voice to attract their attention. Several witnesses commented that you frequently spoke loudly to patients and staff. The panel therefore determined that you did indeed shout the word garlic towards colleagues.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that on an unknown date between 1 December 2017 and 1 April 2018 shouted ‘garlic’ at one or more colleagues.

Charge 2

2. On an unknown date before 21 January 2018, when inserting a Nasogastric (‘NG’) tube, did not take appropriate steps when the patient was in discomfort

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A and also your evidence.

Colleague A's evidence was that the patient was clearly uncomfortable during the procedure and expressed this non-verbally by making noises and moving.

Colleague A's evidence was that:

> '*As the Registrant was attempting to insert the tube, the patient became restless and appeared to be in pain. I told the Registrant to stop and explained that the patient was unlikely to tolerate the procedure, as she was visibly uncomfortable.*
> […]
> *Whilst the Registrant did stop and listened to me in that sense, he challenged me about this afterwards.*'

Colleague A's evidence was that the patient's facial expressions, the noises she made and her restless movements made it clear that she was in discomfort. She stated that she had tried the procedure before you attempted to do so, but had stopped immediately as soon as the patient became uncomfortable. She said that when a patient expresses discomfort, verbally or non-verbally, it is a practitioner's duty to stop and seek further consent from the patient.

In your evidence, you said that you had recognised that the patient was in discomfort and had paused. You said that the patient was still able to tolerate the procedure, albeit you did not check this with the patient nor did you obtain continuing consent from her. You said that you expected the patient to push you away if she could not tolerate the procedure. You therefore continued the procedure until you were stopped by Colleague A.

The panel found Colleague A's evidence to be clear and consistent with her local contemporaneous statement in indicating that the patient was in discomfort. The panel therefore accepted Colleague A's evidence. It concluded that, knowing that the patient was in discomfort, you failed to take the appropriate steps to seek her consent before resuming the procedure.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that on an unknown date before 21 January 2018, when inserting a Nasogastric tube, you did not take appropriate steps when the patient was in discomfort.

Charge 3ii)

3. On 21 January 2018, left Ward 3
   ii) Did not inform Colleague A that you were leaving the Ward.

This charge is found proved.

In reaching this decision, the panel had regard to the evidence of Colleague A and that given by you.

In Colleague A's witness statement she said:

'*On this date,* [Colleague H] *and one Band 5 nurse went for their break, leaving the Registrant and myself as the only nurses on the floor. Without my knowledge, the Registrant broke the protocol and left the Ward, leaving me on my own.*

One of the Registrant's patients was very unwell at the time and had a spiking temperature, however I was unaware that the Registrant had left and continued to deal with my own patients. I was in the process of giving antibiotics when a NA [Nursing Assistant] *approached me and asked me to look at the aforementioned patient, as he was in a side room and he was scoring high with his vital signs.* […] *Due to the fact that I was in the middle of mixing medication, I was not able to stop what I was doing. I told the* [NA] *to find the Registrant, as whilst I knew that I would have to support the Registrant in caring for the patient when I was finished, I wanted someone to attend quickly. The Registrant however was not on the Ward and could not be found.* '

Colleague A confirmed this in her evidence. The panel found that Colleague A's evidence was very clear and consistent with her local contemporaneous statement.

In your written representations you said:

> '*I did not leave the ward without informing a staff member and this was none other than the HCA who was assigned to work with me. I explained to the HCA that I would go to the pharmacy, and it was urgent/ important decision due to the condition of the patient. I emphasized that I could not locate the nurse – in – charge and other nurses*.'

However, your evidence was inconsistent with your subsequent written representations where you said that you knew that the nurse in charge was busy with another patient and you therefore decided to let the nursing assistant know that you were leaving the ward to go to the pharmacy.

The panel preferred and accepted Colleague A's evidence. You accept that you did not tell Colleague A that you were leaving the ward. The panel found it unlikely that if you had told the nursing assistant that you were leaving the ward she would then tell Colleague A twice that she did not know where you were and that she was unable to find you. Therefore, the panel did not accept your explanation that you had told the Nursing Assistant that you were leaving the ward. As an experienced registered nurse you should have known that it was important to inform another registered nurse before leaving the ward and that you should not have left the ward if no other registered nurse was present.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that on 21 January 2018 you left Ward 3 and did not inform Colleague A that you were leaving the Ward.

Charge 4

4. Around April 2018, on one or more occasion, raised your voice to a colleague who was addressing you in your professional capacity

This charge is found NOT proved.

In reaching this decision, the panel had regard to the evidence of Colleague F and that given by you.

Colleague F's evidence was:

'*It was reported to me that the Registrant was irritated by the Staff Nurse's questions over the phone and he started shouting at the Staff Nurse over the phone to stop asking questions.*

[…]

This incident was witnessed by a Healthcare Assistant […]*. However, he felt that he had to intervene as he heard voices raised. This conversation between the Registrant and the agency nurse occured in the Ward outside Room 5. It was therefore highly unprofessional for there to be raised voices in such a public area.*'

Colleague F did not witness these two incidents and, although in her evidence she confirmed that this was her understanding, her evidence was hearsay.

Your evidence was that you were trying to be assertive in a situation where you had been challenged, but did not shout. There was no evidence to corroborate the hearsay evidence of Colleague F and in these circumstances the panel could not be satisfied that this allegation has been proved.

The panel was therefore not satisfied that the NMC has provided enough evidence to demonstrate that it is more likely than not that around April 2018, on one or more occasion, you raised your voice to a colleague who was addressing you in your professional capacity.

Charge 5ii)

5. On 20 April 2018, in relation to Patient H, despite their deteriorating condition;
   ii. Did not refer the patient to the doctor for review and/or

This charge is found NOT proved.

In reaching this decision, the panel had regard to Patient H's clinical notes, communication records and NEWS observation chart together with Colleague B's evidence and the evidence given by you.

In her witness statement Colleague B said:

'*I telephoned the Registrant at approximately 17:00hrs and he confirmed that he was the nurse caring for Patient H. On the telephone, I asked the Registrant if he had referred the patient to the doctors for review. The Registrant responded to say that the patient was reviewed in the morning by the doctors and they were happy with the patient and therefore, he had not informed them of the NEWS of 7, as the score had not changed. He stated that he did not consider it necessary to speak to the doctor again about the patient.*'

Colleague B confirmed this in her evidence.

The patient communication sheet has an entry at approximately 11am which states;

'*NEWS 7 – referred to doctor on ward*'

Your evidence was that you had referred the NEWS score of 7 to the doctor on the ward but did not think it necessary to refer to the doctor again as the NEWS score had not changed.

The panel was satisfied that you had referred the NEWS score of 7 to the doctor on the ward and that you had noted this in the communication sheet.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 20 April 2018, you did refer Patient H to the doctor for review.

Charge 5iii)

5. On 20 April 2018, in relation to Patient H, despite their deteriorating condition;
   iii) When Colleague B asked you about the treatment you provided to Patient H, declined to answer questions.

This charge is found proved.

In reaching this decision, the panel had regard to Colleague B's evidence together with your evidence.

In her witness statement Colleague B's said:

'*When I spoke to the Registrant on 20 April 2018, the Registrant declined to elaborate or answer questions about the patient's condition or plan of care. He kept repeating that the doctor was not concerned in the morning of 20 April 2018 and therefore there was no need to change management.*
It was difficult to understand if the patient was deteriorating from his responses as the Registrant would not (or could not) answer my questions.'

Colleague B confirmed this in her evidence, which the panel found to be clear and consistent.

You stated in your written representations:

> '*I was able to explain/disclose to Colleague B my independent nursing decision as above*'

The panel found that your answer to Colleague B's questions did not explain the situation as you declined to answer the question posed.

The panel preferred Colleague B's evidence to yours.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 20 April 2018, in relation to Patient H, despite their deteriorating condition, you declined to answer questions when Colleague B asked you about the treatment you provided to Patient H.

Charge 6

> 6. On 20 April 2018, in relation to Patient O, despite their deteriorating condition, did not refer the patient to the doctor to review

This charge is found proved.

In reaching this decision, the panel had regard to Patient O's NEWS chart, the clinical notes and the communication record together with Colleague B's evidence and that given by you.

In her witness statement Colleague B said:

> '*On 20 April 20118 there was another incident involving a patient* […] *Patient O. This patient had been in hospital from 19 April 218.* […]

During my evening checks on this patient's Vital PAC notes, I noted that Patient O had deteriorated throughout the day as 15:45pm Patient O had a NEWS of 12.
As this was particularly concerning, I telephoned the ward and asked to speak to the Registrant as he was the nurse who was allocated to this patient. When I spoke to the Registrant about this, he was not able to provide me with a clear indication as to the action plan in relation to this patient. The registrant told me that he had not informed the doctor of the patient's deterioration. However, this was not the correct procedure to follow.
The Registrant should have asked the doctor to review the patient after the patient had scored a NEWS 12, at 15:45hrs, as the vital signs had continued to deteriorate from the morning.'

Colleague B confirmed this in her evidence. The panel found her evidence to be cogent and consistent. Colleague B said that she was not able to ascertain from you a clear action plan whether you had informed the doctor about the deterioration and why the patient observations had been decreased in frequency from 30 minutes to 4 hours by you, with no new observations recorded by you.

The panel found your written representation to be convoluted and was not able to extract from it whether you had informed the doctor of the deterioration in the patient's condition. In your evidence you stated that you had escalated the deterioration to a doctor twice. However, there was no entry to that effect in the patient communication record or clinical notes.

The panel therefore preferred Colleague B's evidence to yours and therefore concluded that you did not refer the patient to a doctor for review.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 20 April 2018, in relation to Patient O, despite their deteriorating condition did not refer them to the doctor to review.

Charge 7i)

7. On 23 April 2018

i) Directed Colleague C to administer medication to Patient H when she it was not appropriate for her to do so and/or

This charge is found proved.

In reaching this decision, the panel had regard to Patient H's communication record, Colleague C's and Colleague F's evidence, Colleague C's local contemporaneous statement and to your evidence.

In her witness statement Colleague C said:

'*The Registrant dispensed Patient H's medication and then left the medication in a medication pot on her tray, next to her breakfast. The registrant then went to attend to a patient in the next bed. The Registrant asked me to administer the medication to Patient H. However, I informed him that as a HCA, I was not allowed to give out medication. The Registrant responded to this with a sigh and said "why? I am watching you it's fine". I explained to the Registrant that I was not allowed to administer medication to Patient H, nor did I feel comfortable doing so. The Registrant then went on to say that if he says that it is ok, then it is. Once again I refused to administer the medication.*'

Colleague C also confirmed this in her evidence which was consistent with her contemporaneous written statement made to Colleague F:

'*During the morning around 08:15 I was assisting Patient* [H] *with her breakfast, Nino was attending to the patient in the next bed. He asked me to give* [Patient H] *her morning tablets, I replied 'I am not allowed to give medication' to which he sighed and then said 'why? I am watching you its fine' I explained that I am not allowed nor do I feel comfortable doing what he was asking me to do. Nino went on to tell me that if he says it's ok then it is. I told him again I'm not going to do it because I'm not legally allowed.*'

In your written representations you said:

> ‘*When I asked for help from the HCA to administer the medications (only oral medications), I did not fail to give an explanation. I emphasized that the patient was reluctant despite several attempts (of giving/ offering/ to give/ offer oral medications). I also added that I would stay while observing some distance enough for me to witness (while I observe from a distance) the administration of medications.*
>
> *Asking for help from colleagues in relation to medication administration is considered acceptable/ reasonable in various nursing homes (my previous employers) for as long as the administration of medications is witnessed, particularly in the case of people with Parkinson’s Disease as there are certain medications which are required to be taken regularly. Strict adherence is deemed important.* ‘

You confirmed this in your evidence.

The panel was therefore satisfied that you did ask Colleague C to administer the medication to Patient H.

The panel then considered whether it was appropriate for you to do so. You said that this was common practice in your previous position in a care home.

Colleague C’s evidence was that giving medication was not in the remit of an HCA and that it was not common practice at the Trust for HCA’s to do so. In her evidence Colleague F confirmed that this was correct according to Trust policy. You had completed the relevant induction and training in medications administration at the Trust, including working on drug administration, with Colleague H and Colleague G (on 30 November 2017), completion of Medicines Management training module in December 2017 and being assessed on the Ward. The panel was satisfied that you had been given ample

opportunity and training to learn what the Trust's medical administration policy was and how it was applied in practice and that you knew or ought to have known that it was not permitted for an HCA to administer medication.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 23 April 2018, you directed Colleague C to administer medication to Patient H when it was not appropriate for her to do so.

Charge 7ii)

7. On 23 April 2018
   ii) Stormed over to Patient H and/or

This charge is found proved.

In reaching this decision, the panel had regard to Colleague C's and Colleague F's evidence, Colleague C's local contemporaneous statement together with your evidence.

In Colleague C's written statement she said:

> '*The Registrant then stormed over to Patient H, threw her head back and tipped the contents of the medication pot into Patient H's mouth and then walked off to attend to the patient he was attending to previously. I cannot recall the number of tablets in the medication pot, however, I think there were more than six tablets.*'

This was consistent with Colleague C's evidence end her contemporaneous local contemporaneous statement:

> '*Nino then tutted loudly and walked over to* [Patient H]*'s bedside where she was lay, put his hand under her chin tilted her head back and poured numerous tablets into her mouth in one go and returned back to the patient he was with previously.*'

The panel found Colleague C's evidence to be cogent and compelling. She was able to recall the events in detail. She described you as 'huffing and puffing' and walking very fast

as indicating that you stormed over to Patient H. The panel preferred her evidence to your evidence.

You said that you would not lose your temper and that your approach to the patient could not properly be described as ‘storming’. However, in your written representations you merely stated that you did not recall the incident as you had not behaved in this manner.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 23 April 2018, you stormed over to Patient H.

Charge 7iii)

7. On 23 April 2018

iii) Threw Patient H’s head back and/or

This charge is found proved.

In reaching this decision, the panel took into account Colleague C’s and Colleague F’s oral and written evidence. Colleague C’s local contemporaneous statement as well as your oral and written evidence.

The panel reminded itself of its findings with regards to charge 7ii).

It had regard to Colleague C’s evidence that you forced back the patient’s head by placing your hand on her chin and pushing her head. You did not address this in your written representations. Your evidence however was that you were not in any way harsh in your treatment of the patient, that you merely applied a gentle touch when lifting her chin applying no force.

However, in the light of its finding under charge 7ii) the panel preferred Colleague C’s description which was consistent and clear.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 23 April 2018, you threw Patient H's head back.

Charge 7v)

7. On 23 April 2018
   v) Did not remain with Patient H to supervise her safe digestion of the tablets and/or

This charge is found proved.

In reaching this decision, the panel had regard to Colleague C's and Colleague F's evidence, Colleague C's local contemporaneous statement together with your evidence.

The panel reminded itself of its findings with regard to charge 7ii) and 7iii).

Colleague C's evidence was that having tipped some 6 tablets into the patient's mouth, without giving her a drink, you left her and returned to another patient.

Your evidence was that you checked the patient's mouth to ensure safety, this being your usual practice.

However, in the light of its findings under charge 7ii) and 7iii) the panel again preferred Colleague C's evidence which was consistent and clear to yours.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 23 April 2018, you did not remain with Patient H to supervise her safe digestion of the tablets.

Charge 7vi)

7. On 23 April 2018

vi) Did not promptly return to Patient H when Colleague C informed you that they were choking.

This charge is found proved.

In reaching this decision, the panel had regard to Colleague C's and Colleague F's evidence, Colleague C's local contemporaneous statement together your evidence.

In her witness statement Colleague C said:

'*At this point, Patient H was choking, so I ran over to her to help. I pulled her forward to stop her choking and shouted to the Registrant to ask for help. The Registrant was looking at a medication chart of another patient at the time and simply responded to me saying "I'll be with you". The Registrant did not seem to understand the urgency of the situation. He told me to give Patient H a drink of water but continued to administer another patient's medication.*'

This was confirmed in Colleague C's evidence and contemporaneous local statement:

'[Patient H] *immediately began to choke and due to* [Patient H] *being unable to hold her body weight I brought her forward.*

Nino witnessing this remained where he was and said 'yes she has been sick for a few days now' and asked [Patient H] *if she needed an anti-sickness tablet.* [Patient H] *was clearly unable to answer this question due to the fact that she'd been chocking on the tablets Nino had just thrown down her throat. Nino told me to give her a drink of water but continued administering another patient's medicines. During the 5 minutes that* [Patient H] *continued to cough and eventually vomited Nino made no eye contact with her nor came over to see if she was OK.*'

Colleague C also said that, after Patient H had stopped choking she went to inform the nurse in charge what was happening. Upon her return, Colleague C said that you had moved on to the next patient's bed, which was further away from Patient H.

In your written representations you said:

> '*I went to Patient H and intervened accordingly (assessed airway and breathing) when the HCA reported that Patient H was "?" choking. I had spent enough time with Patient H and waited until condition became stable. First aid was rendered. I also notified the doctor.*'

Your evidence was that when informed by the HCA you did not say '*I'll be with you*' but went to the patient and intervened as aforesaid.

However, again in the light of its findings under charge 7ii) and 7iii) the panel preferred Colleague C's evidence to your evidence as Colleague C was consistent and cogent when describing the events.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 23 April 2018, you did not promptly return to Patient H when Colleague C informed you that they were choking.

Charge 8)

> 8. On 23 April 2018 did not take prompt action when Colleague C informed you that Patient S had passed loose stools

This charge is found proved.

In reaching this decision, the panel had regard to Colleague C's evidence, Colleague C's local contemporaneous statement together with your evidence

In her witness statement Colleague C said:

> '*At around 9:30am on that shift, I informed the Registrant that a patient had passed loose stools twice, to which the Registrant looked at me and gave no response.* […].
> *At around 11am I asked the Registrant if he would like me to send a stool sample as Patient S had had a loose bowel movement five times by that point. The Registrant stared at me and said "*[Colleague C]*, you are supposed to be working with me, when someone goes three times you have to tell me". I explained to the Registrant that I had told him that Patient S had passed loose stools after the second and third times and the subsequent times had happened in the last half an hour and I had not had time to inform the Registrant. The Registrant replied saying "if you don't inform me this teamwork does not work". By this time, I had spoken to* [Colleague F] *who had advised me to send a stool sample, as I did not feel that the Registrant was listening to my concerns.*
>
> *I cannot recall the times at which Patient S passed loose stools. I did not record anywhere that I had informed the Registrant of this.*
> *When a patient has loose stools, our practice is to inform the nurse we are working with, who will, if the patient has passed two to three loose stools, ask us to send a sample and to immediately move the patient into their own room. This is done even before the sample results have been returned in case the patient has an infection.*'

Colleague C confirmed this in her evidence, this was also consistent with her local contemporaneous statement. She said that she had been unable to inform you immediately of the fourth and fifth loose stools as, at the time, she had been attending to Patient S in the toilet.

In your written representation you stated:

> '*The HCA managed to monitor the episodes of Patient S's bowel motion, however failed to maintain effective communication. I was not notified of further episodes of loose stools. If I were the HCA at that time, I would inform the nurse promptly,*

especially when Patient S had exceeded the fourth episode. There were also other patients I needed to look after, not only Patient S. '

In your evidence you said that it was not until you saw the entry in the fluid check sheet that you were aware that the patient had opened her bowels four times that morning. You were not immediately able to refer this to the doctor but emphasised the need for a stool sample. You confirmed these matters and said that the HCA should always inform you when this patient opened her bowels.

In her evidence Colleague C said that she had spoken with Colleague F as she felt that you were not listening to her concerns.

The panel preferred Colleague C's evidence to yours. Colleague C was consistent and clear when describing the events.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 23 April 2018, you did not take prompt action when Colleague C informed you that Patient S has passed loose stools.

Charge 10i)

10. On 23 April 2018

    i) Did not take prompt action when Colleague C informed you that Patient M was in Pain and/or

This charge is found proved.

In reaching this decision, the panel had regard to Colleague C's evidence and her local contemporaneous statement together with your evidence.

Colleague C stated in her witness statement:

> '*At around 18:30, a patient called* [Patient M] *was complaining of pain in her feet. It was very unusual for Patient M to complain of being in pain* […] *She told me that her pain score was 8 out of 10. I explained to Patient M that I would inform the Registrant* […]
>
> *I then went to the Registrant, who was sat at the nurses station on his phone, and said to him that Patient M was complaining of being in pain. The registrant replied to this saying "she was fine an hour ago, the dressing will just be too tight". I replied saying "she only has one of her feet dressed yet both of them are hurting her". The Registrant then said "I am too busy I'll be with her". At this point, I said to the Registrant "you have told me that I haven't been informing you of relevant information yet now I am telling you that a patient is in pain and you are sat on your phone" The Registrant carried on looking at his phone and laughed. I can recall he was scrolling through social media.*
>
> *Staff Nurse* [3] *witnessed this conversation and challenged the Registrant on his behaviour. The Registrant then argued with Staff Nurse* [3] *about it but did get up to attend to Patient M. I cannot recall what the Registrant said to Staff Nurse* [3].'

Colleague C confirmed this in her evidence and also in her contemporaneous local contemporaneous statement.

In your written representations you stated:

> '*Patient M was exaggerating her symptom. When Colleague C approached me, Patient M had verbalized tolerable pain perception with pain score of 3 – 4 out 10 (0 as no pain and 10 as most painful) and refused pain medication during my last medication administration round – ''not long ago'' (contrary to the report – an hour ago). I had asked for the pain score a few times before I left Patient M. Patient M was somehow unable to give exact description of pain in her foot. Patient M had*

also confirmed that both the dressing and stockinet protecting the affected area were not tight.

Colleague C could have influenced Patient M to exaggerate her symptom ("?" factitious disorder – malingering).

I was only using my mobile phone to complete/calculate the fluid balance of patients (still a work – related activity).'

You confirmed this in your evidence and further said that you went over to check the patient of your own accord, not prompted by Staff Nurse 3.

The panel found that Colleague C's evidence was clear and consistent and was maintained when she was cross examined. Despite your contention that Colleague C could have influenced the patient to exaggerate the pain, the panel found no evidence in support of this. Furthermore, the panel found that, regardless of your assumption as to why the level of pain had changed, you should have checked the patient promptly upon receipt of the information from Colleague C, but did not do so.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 23 April 2018, you did not take prompt action when Colleague C informed you that Patient M was in pain.

Charge 10ii)

10. On 23 April 2018

    ii) Laughed/scrolled on your mobile phone when Colleague C was providing information to you about patients.

This charge is found proved.

In reaching this decision, the panel had regard to Colleague C's evidence, Colleague C's local contemporaneous statement together with your evidence.

In your evidence you said that you were using your phone only to calculate a fluid balance, a work related activity. Furthermore, that although, this being your nature you might have smiled when Colleague C gave you information about Patient M, you did not laugh.

Colleague C said that you were seated at the nurses's station and that she had leaned over the desk to speak with you. She said that the fluid balance charts were paper based. She said that you were not using the calculator on your phone and that she had seen some form of social media on the screen.

The panel found Colleague C to be consistent in her evidence and her witness and contemporaneous statement and also under cross examination. Furthermore, a number of witnesses described you as being quite commonly found on your phone. Colleague C confirmed that you were not on your break during which you would be able to use your phone, as all nurses spend their breaks in the staff room.

The panel reminded itself of its findings regarding charge 10i). The panel therefore preferred Colleague C's evidence to yours.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 23 April 2018, you laughed/scrolled on your mobile phone when Colleague C was providing information about patients.

Charge 12iv)

12. On 20 August 2018

iv) Unnecessarily woke a patient up to offer paracetamol and/or

This charge is found NOT proved.

In reaching this decision, the panel had regard to Colleague I's evidence and her local contemporaneous statement together with your evidence

In her witness statement Colleague I stated:

> '*In addition, when attending to another patient who was asleep in bed, the Registrant woke her up to ask her whether he* [sic] *wanted any paracetamol. The patient looked very comfortable and did not look like she was in pain.'*

This was consistent with Colleague I's evidence and her local contemporaneous statement:

> '*Another pt* [patient] *was asleep in bed and he wanted to ask the pt if needing paracetamol. I've told him that pt quite comfortable and the paracetamol is only PRN. He replied to me that there is nothing wrong to just ask the pt and still tried to call the pt, trying to wake her up, but the pt just looked at him and didn't even replied as she still sleepy.* [sic]

The panel found Colleague I's evidence to be clear and consistent

In your written representations you said:

> '*Offering Paracetamol happened during a medication administration round. It was deemed necessary/ important to wake the patient up as the patient would be given due medications. The patient had complained discomfort (cannot recall the affected area) and taken Paracetamol prior to this incident (during the previous medication administration round).*'

In evidence, you said that this patient required other medication in addition to the Paracetamol and that is why you had woken her up.

There was before the panel no evidence, for example the patient mediation administration charts or clinical notes, to demonstrate that this did not occur during a medication round. Further, it was unclear whether the patient needed to be given any other medication. The

panel could therefore not be satisfied that there was not a good reason to waken the patient to offer paracetamol.

The panel was therefore not satisfied that the NMC has provided enough evidence to demonstrate that it is more likely than not that, on 20 August 2018, you unnecessarily woke a patient up to offer paracetamol.

Charge 12v)

12. On 20 August 2018

v) Communicated poorly with a patient about their anti-sickness patch.

This charge is found proved.

In reaching this decision, the panel had regard to Colleague I's evidence and her local contemporaneous statement together with your evidence.

In her witness statement Colleague I states:

'*I also recall the Registrant asked another patient whether she was feeling sick, whilst the patient was eating her meal. Firstly, it was not appropriate to disturb the patient to ask this whilst she was eating. Secondly, I recall the registrant asked the patient if she had removed her anti-sickness patch, to which the patient replied, "why would I do that?". The Registrant then said sarcastically" because I saw you, you've been to the toilet".*

I think the Registrant was saying that as he had seen the patient go to the toilet, she must have gone to be sick. He did not think that the patient might have gone to the toilet for another reason. The patient was very annoyed by this as she said something to the effect of "why do I need to argue with you in the middle of my meal?".'

The panel found that this was consistent with her evidence and her local contemporaneous statement. Colleague I's evidence was clear and consistent. She

described how the patient was clearly annoyed about being questioned about this matter during her meal. Colleague I further described your interactions with patients as very poor.

In your written representations you said:

> '*I mentioned to the patient the other use – ''helps to reduce excessive oral secretions/ control hyper – salivation''. The patient was dribbling at that time.*
>
> *Please see hyoscine patch indications*.'

You said in your evidence that it was not inappropriate to ask the patient whether she had removed the patch when she visited the toilet. Further, that although the patient was eating, you had approached her during the medication round. You further denied arguing with her.

The panel concluded that it was inappropriate to raise these matters whilst the patient was eating. It was satisfied by the consistency of Colleague I's account that you argued sarcastically with the patient about her response to your questions.

The panel determined that your interaction with the patient was confrontational and not appropriate.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 20 August 2018, you communicated poorly with a patient about their anti-sickness patch.

Charge 14i)

> 14. On 28 August 2018
>
> i) You attempted to give oral medication to a patient when he was too drowsy to take them and/or

This charge is found proved.

In reaching this decision, the panel had regard to Dr 1's evidence and her email to Colleague F together with your evidence.

The panel had regard to Dr 1's email to Colleague F, dated 28 August 2018:

> '*I was looking after a patient in Bay 1 who became acutely unwell on that morning of the 22nd. This gentleman had developed a high temperature, had become very drowsy and had an increased heart rate. Nino was assisting another staff nurse in the bay.*
>
> *While assessing the patient in his chair, Nino arrived and began trying to give the patient his oral medication when clearly he was too drowsy to be able to safely swallow these. I explained this to the staff nurse in question, he replied by saying he'd been asked to get them and needed to give them to the patient. I had to very clearly state that it was not safe and I could not allow them to be given.*'

The panel found that Dr 1's oral evidence was cogent and consistent with her local contemporaneous statement. She described how she was trying to carry out an urgent medical assessment of the patient, and found him to be too drowsy to safely take oral medication. Dr 1 said that she had had to ask you twice to refrain from administering the medication; the first time that she had asked you to stop, there was 'push back' from you.

Dr 1 explained that she had raised her concerns on the day of the incidents to Ward Manager, Colleague F. Dr 1 confirmed that she had been sufficiently concerned about your actions to send the Matron her email dated 28 August 2018.

In your written representations you state:

> '*Whenever I administered medications, I always assessed general condition of each patient. A risk assessment was always a priority to prevent or minimize both actual and potential harm.*
>
> *Patients who are unwell sometimes need to skip their oral medications (omission).*

My senior nurse however, still wanted me to give the oral medications after I had emphasized many times that the patient was restless/ unwell and could not tolerate the medications.'

In your evidence you said that you had explained to the doctor that your senior nurse had required you to administer the medication but you desisted when Dr 1 stated that to do so was unsafe.

The panel was not satisfied by your response to this charge and concluded that you missed the mischief in this charge. Although you explained that the senior nurse insisted that you give the patient his medication the panel found this to be implausible in the light of the patient's condition.

The panel found Dr 1's evidence to be clear and cogent and therefore preferred it to yours.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 28 August 2018, you attempted to give oral medication to a patient when he was too drowsy to take them.

Charge 14ii)

14. On 28 August 2018

ii) You prematurely attempted to remove a blood pressure cuff and/or observations machine from a patient.

This charge is found proved.

In reaching this decision, the panel had regard to Dr 1's evidence, Dr 1's email to Colleague F together with your evidence.

In Dr 1's email to Colleague F, dated 28 August 2018, she said:

> '*With the help of a HCA I moved the patient to his bed to monitor him. I got the observation machine in the bay and attached it so I could monitor* [h]*is vital signs more closely. While trying to cannulate the patient Nino came over and tried to remove the blood pressure cuff and take the observations machine. Again I had to explain that this patient was unwell and I was having to monitor him more closely, as he had dropped his oxygen saturations and was now needing oxygen. Nino told me that regular obs were due on another patient in the bay so he needed the machine. I explained that those could wait and clearly this man's need to monitoring was great at present.*
>
> *Thankfully the other staff nurse* […] *in the bay came to assist me with the patient. Throughout this time however, Nino continued to interrupt her to tell her about normal blood sugar results for other patients in the bay.*'

In her evidence Dr 1 stated that while she was conducting the A to E assessment you approached the bed and reached out to the cuff whereupon she had to 'hold you back'. The panel found that Dr 1's evidence to be clear and consistent with her local contemporaneous statement. When questioned by Mr Knibbs as to why the email to Colleague F was written a few days after the event Dr 1 was able to give a clear explanation and to indicate that it was a true account of the incident. Dr 1 refuted Mr Knibbs' suggestion that she had been told negative things about you by the nursing staff before writing her email.

In your written representations you said;

> '*I did not do that. Taking blood pressure is considered as one of the most basic clinical procedures. I know how to take a patient's blood pressure and particularly how to put on and remove blood pressure machine cuff.*'

Your evidence was that you asked Dr 1's permission to remove the machine for use with your unwell patient and that you did not attempt to remove the cuff. The panel found that

your response did not address the underlying regulatory concerns of this charge and did not find your reply satisfactory.

The panel found Dr 1's evidence to be cogent and consistent and therefore preferred her evidence to yours.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 28 August 2018, you prematurely attempted to remove a blood pressure cuff and/or observations machine from a patient.

Charge 16i)

16. On 24 August 2018

i) On one of more occasions laughed inappropriately during the medication round and/or

This charge is found proved.

In reaching this decision, the panel had regard to Colleague G's evidence and the local investigation report together with your evidence.

In her witness statement Colleague G states:

'*I recall that the Registrant laughed out loud at a number of occasions throughout the medication round. These episodes were frequent but spaced out throughout the medication round. He would laugh out loud inappropriately perhaps every 10 minutes or so. The Registrant did not demonstrate an awareness about how these episodes made people feel around him. I cannot recall whether I challenged the Registrant about this specifically, or what the Registrant said in response.*

However, I recall a more specific incident when the Registrant attended to a patient in room 2 in the Ward

[…]

He was receiving End of Life care.

[…]

The patient's family was in the room. The Registrant asked the family members to wait outside the room while the Registrant administered the medication.

[…]

However, I recall that we had commenced the phenytoin infusion and we were both by the sink washing our hands. There were family photos on the patient's bedside table and whilst I was washing my hands, the Registrant looked towards the photographs and laughed. There was nothing funny about the photos, nor the situation.'

Colleague G in her evidence referred to the frequency of your episodes of laughing during a medication round. She said that you would 'laugh out loud' and was able to describe the volume and manner of your laughs as being audible from a few steps away.

She described in detail the incident about photographs and her concern that your laughter may have been heard by family members who were outside the room.

The panel found Colleague G's evidence to be cogent and consistent. It determined that her evidence was similar to other evidence that the panel had heard from witnesses about you laughing at inappropriate times.

In your evidence you denied that you were laughing and explained that you were just smiling and that you were in general a happy person. You said you did not recall making a sound when you smile. However, when you laugh you do produce a sound.

The panel preferred Colleague G's evidence. It found that her evidence was in line with other witnesses who had observed you smiling and laughing at times which were inappropriate. The panel therefore concluded that you did laugh during the medication round.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 24 August 2018, on one of more occasions you laughed inappropriately during the medication round.

Charge 16ii)

16. On 24 August 2018

ii) On one or more occasions, shouted 'open' to a patient following administering medication and/or

This charge is found proved.

In reaching this decision, the panel had regard to Colleague G's evidence and the local investigation report together with your evidence.

The investigation report stated:

'*The investigation learnt that NY* [Mr Yraola] *was working alongside and was witnessed by and independent assessor – a clinical Education Facilitator from the learning and Development team.* [Colleague G] *is an experienced nurse and has vast experience in coaching overseas nurses and preparing them for the Objective Structured Clinical Examination (OSCE) training as well as having had breadth of experience working in learning environments, with clinical simulation learning and nurse competency assessment.*'

In her witness statement Colleague G stated:

'*I also recall that the Registrant spoke inappropriately to another patient during the drug round. I recall that the Registrant had administered the patient his oral medications.*[…] *It had taken a while to administer the drugs to the patient as the patient had a number of tablets to take and also needed support with handling his cup of water. Once the Registrant had administered the patient all of his due medications, the Registrant shouted "open" to the patient as he wanted to check that the patient had swallowed the tablets.*

I cannot recall whether the patient said anything to the Registrant, however, he was clearly offended by the Registrant's comment.
This was the second time that the Registrant had shouted "open" to a patient during the medication round, having just done it to the patient in the previous bed.'

This was confirmed in Colleague G's evidence and in the local investigation report:

'[…] *Nino had administered the patient his due medications. This had taken a while as the patient had a number to take and needed support with handling his cup of water etc. At the end of this, Nino shouted "OPEN" to the patient – indicating that he wanted to check that the patient had taken all the medications. The patient was clearly offended by the nature of the comment. Nino repeated this with the patient in 1D and at that point I asked him not to do it.*'

In your written representations you said:

'*I never shouted 'open'. It was a polite request. I always checked the mouth of each patient to ensure safety.*'

The panel considered whether in using the word 'open' you did shout. The panel accepted that Colleague G (a highly experienced clinical educator) was providing you with support and supervision of your clinical practice on this shift. As such, the panel found that Colleague G had observed your actions and behaviours, with close attention to detail. Colleague G's evidence was cogent, reliable and consistent and she maintained her position under cross examination. The panel preferred her evidence and did not accept your evidence that it was a polite request. The panel therefore accepted the evidence of Colleague G and determined that you had shouted the word 'open' at patients on more than one occasion.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 24 August 2018, on one of more occasions you shouted 'open' to a patient following administering medication.

Charge 16iii)a)

16. On 24 August 2018

iii) When informed by a Care Support Worker ("CSW") that a patient was suffering chest pain

a. Did not give the CSW an appropriate management plan for the patient and/or

This charge is found proved.

In reaching this decision, the panel had regard to Colleague G's evidence and the local investigation report together with your evidence.

In her witness statement Colleague G stated:

'*During the medication round, the Care Support Worker ("CSW") approached the Registrant to inform him that a patient in Bay 1 was complaining of chest pain.* […] *The Registrant's immediate response to this was to look at his handover sheet and he then said "I have given him some isosorbide so it is ok". I stood back for approximately 15 seconds to see what other response the Registrant gave. The Registrant did not give any further instruction.*

At this point, I felt that I had to intervene and so I advised the CSW to record a set of observations immediately, to transfer the patient to the bed and to inform the other Staff Nurse who was also assigned to the Bay with the Registrant […]

In this situation, I expected the Registrant to respond in the way that I did to the CSW. I expected the Registrant to give the CSW a management plan for that patient […]'

The panel found that this was consistent with Colleague G's evidence and the local investigation report:

'*When we were in Bay 3, the CSW from Bay 1 approached us both and said that the patients in 1F had some chest pain. Nino replied "I have just given him his isosorbide so its ok". He did not give the CSW any other advice or make an attempt*

to stop the drug round, lock up the drug trolley and go to see the patient. I advised the CSW on the appropriate course of action.'

In your written representations you state:
'*Before the medication administration round, the colleague who was assigned to complete my medication administration competency had emphasized that I needed to focus on the medications of the patients who were in rooms "1" and "3" while the actual nurses who were allocated for the two rooms respectively would take charge and carry out other daily routine ward tasks. I was reassured by my senior colleague's instructions.*

I decided to administer the medications of patients in room "1" first. One of the patients admitted in room "1" was the patient who had been reported to have an episode of chest pain. I was in room "3" giving medications to a patient when CSW approached me and reported that there was a patient in room "1" who had just experienced an episode of chest pain. It was obvious that I was with a patient in the middle of medication administration when I was notified of the event. I listened to what CSW had to say. I explained that the patient had already taken an Isosorbide tablet (a regular prescribed medication). My subsequent reply was to inform the nurse assigned in room"1" since I could not leave the patient at that time as I was giving medications. This was witnessed by my assessor. I did not review the patient immediately due to the given circumstance. However, when I had finished giving medications, I returned to room "1" to see the patient.'

The panel preferred Colleague G's evidence to your evidence. The panel found that Colleague G's evidence was detailed and clear. She had given you the opportunity to deal with the situation however, observed that you failed to do so and had to step in. Your response was to advise the CSW that you had given the patient isosorbide, which the panel concluded was irrelevant to the situation. Further, in your written representations, you said that the patient was confused and that this explained your approach to him. You said that you wondered if the patient was trying to complicate events for you by altering his

clinical manifestations deliberately. The panel determined that this did not amount to a management plan.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 24 August 2018, when informed by a CSW that a patient was suffering chest pain did not give the CSW an appropriate management plan for the patient.

Charge 16iii)b)

16. On 24 August 2018

iii) When informed by a Care Support Worker ("CSW") that a patient was suffering chest pain

b. Did not escalate the patient to senior nursing and/or medical staff.

This charge is found proved.

In reaching this decision, the panel had regard to Colleague G's evidence and the local investigation report together with your evidence.

During the Trust's disciplinary investigation, you said that you did escalate the situation to Staff Nurse 3, whom you believed to be the actual nurse in charge of the patient. However, this was clarified during the disciplinary investigation with Colleague G who verified that she had intervened and advised the HCA to inform the other staff nurse in the bay. In your written representations and in your evidence you said that it '*took some time*' and '*a while*' for you to report to the Staff Nurse 4 about the patient's episode of chest pain. However, you were unable to be more specific about what you meant by '*some time*'. The panel found your account to be inconsistent and vague.

The panel reminded itself of the evidence and its findings with regard to charge 16iii)a). For the same reasons as stated above, the panel preferred Colleague G's evidence to your evidence.

The panel therefore found that you did not escalate the matter appropriately with senior nurses or other medical staff, instead you merely informed the CSW to inform another staff nurse. The panel found that instructing the CSW to inform another staff nurse of the patient's situation did not amount to an appropriate escalation.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 24 August 2018, when informed by a CSW that a patient was suffering chest pain did not escalate the patient to senior nursing and/or medical staff.

Charge 17)

17. On 06 November 2018, laughed and/or talked to yourself during a medical procedure a doctor was performing on a patient.

This charge is found proved.

In reaching this decision, the panel had regard to Colleague D's evidence and the local investigation report together with your evidence.

The daily assessment sheet filled in by a HCA stated:

'*What requires improvement (and why)?*
Nino at times it does appear that he is talking to himself and laughing at inappropriate times. When Nino is walking up the corridor the laughing has been quite "off putting".
One of the occasion where Nino has been laughing to himself was in the ENT clinic.
The patient required to have a fibre optic camera through the nose to see their voicebox due to 2 week refferal ? cancer,
Whilst the doctor was performing this test both myself and the doctor were silent and I could hear Nino "chuckling" to himself. When i look at Nino he had his eyes closed and appeared to be talking to himself, after around 8-10 second Nino opened his eyes and saw me looking at him, he then looked at the ground.' [sic]

In your written representations you deny laughing or talking to yourself; you said you were paying full attention to the procedure. Your evidence was that you produce a sound when you laugh.

The staff nurse, who wrote the daily assessment, was not called as a witness by the NMC. However, the panel has seen other daily assessment sheets covering 5 to 9 November 2018 which record that you had laughed and or talked to yourself on other occasions. The panel was therefore satisfied that on this occasion you did laugh and talk to yourself.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 6 November 2018, you laughed and/or talked to yourself during a medical procedure a doctor was performing on a patient.

Charge 18)

18. Between the beginning of November 2017 and the end of November 2018 other than on the occasion referred to in charge 18 above, on one or more occasions, laughed and/or talked to yourself during shift.

This charge is found proved.

In reaching this decision, the panel had regard to the evidence of Colleague D and Colleague J, to the local investigation report, including the daily assessment sheets and to your evidence.

In your written representations and in your evidence you said:

‘*Smiling is different from laughing. I invite the adjudicators to the actual report about being a naturally smiley person.*’

Colleague D in her witness statement said:

> '*On 7 November 2018, Staff Nurse* [5] *completed a further Daily summary Assessment sheet.* […]*. Staff Nurse* [5] *has documented that the Registrant "demonstrated odd, strange behaviour, continued to laugh inappropriately and talks to himself"*

Colleague J in her witness statement said:

> '*From a clinical point of view, the Registrant appeared to be doing fine. However, back in January 2018, members of staff had begun to raise concerns about the Registrant's behaviour. They expressed that at times he would act in a way which was inappropriate, such as walking down the corridor laughing to himself, arguing with them or talking over them. It's difficult to describe the Registrant's behaviour, however, it was bizarre and often at times very inappropriate. Such as interrupting others when they were speaking, ignoring the question asker and responding to another person present, covering his mouth when speaking, laughing when serious concerns were put to him and tic type behaviour (twisting his hair, pulling faces, profuse sweating).*'

The panel also had regard to the following entries in the daily assessment sheets:

5 November 2018 (Staff Nurse):

> '[Staff Nurse 5] *asked Nino questions about his personal circumstances in order to get to know him but he burst out with uncontrollable laughter for an unusual length of time.*
>
> [Staff Nurse 5] *felt that he was a strange character but adhered to the NMC code at all times. No concerning bad behaviour, just put it all down to first day nerves.*'

7 November 2018 (Staff Nurse):

> '*Demonstrating odd, strange behaviour, continues to laugh inappropriately and talking to himself – Disappears for short periods of time with no explanation.*'

8 November (HCA):

> '*Continues to display strange behaviour – talking to himself, laughing and: dance like movements in corridors.*'

9 November 2018 (Staff Nurse):

> '*He went from a high pitched laugh, talking to himself in front of pts to accusing staff of completing tasks/decisions incorrectly.*
>
> […]
>
> *No professionalism in front of patients he is laughing to himself and talking to himself in appropriately.*'

In her evidence Colleague E said:

> '*He would smile a lot, spend a lot of time with a vocal sound that came with the smile. Hard to distinguish if nervous, privately amusing, or sniggering at me. It's a hard call and I don't know the answer.*
>
> […]
>
> *He was continually smiling and vocalising, sniggering. I did try very hard to understand him.*'

The panel found the evidence given by Colleague D, Colleague G and Colleague J to be clear and consistent. Their evidence was corroborated by the entries in the daily assessment sheets, which were filled in by several individual staff nurses and HCAs. Your evidence was that you were 'just a smiley person' and that this had been misconstrued. You said that you may have talked out loud when trying to remember your tasks. However, you also said that you do not recall making a sound when you smile but that you produce a sound when you laugh. The panel preferred the evidence of Colleague D, Colleague G and Colleague J to your evidence. In combination with the daily assessment sheets, the panel concluded that it was more likely than not that you had been laughing and talking to yourself at inappropriate times.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, between the beginning of November 2017 and the end of November 2018 other than on the occasion referred to in charge 18 above, on one or more occasions, laughed and/or talked to yourself during shift.

Charge 19i)

19. On 09 November 2018

i) Viewed an image of a naked adult female on your phone in the 'Children's Play Area' and/or

This charge is found proved.

In reaching this decision, the panel had regard to Colleague E's evidence and her local investigation statement together with your evidence.

In your written representations you stated:

'*I was only sitting in the Children's Play Area (in the corner) checking text messages. I did not do that (not my usual practice). I did not show my phone to other people.*'

In her witness statement Colleague E stated:

'*On 9 November 2018, Nino was sitting in the corner of the children's playroom, I must have been either looking for him as I had not seen him back after the lunch break or passing through and noticed him. His back was against the wall, he had his headphones in and was laughing and giggling. As I approached, he took his headphones off and stood up as if to signal that his lunch break was over. As he stood up I saw a glimpse of his phone as he was lowering his phone to switch it off and saw an image of a lady's naked torso.*'

This was consistent with her local contemporaneous statement:

> '*On the 9 November I was asked to work with a male staff Nurse. Previously we had set up a clinic together were I had had to encourage him to find and partisipate in getting rooms ready.*
> *He had had to be located by myself where I had found him (back against a wall – head phones in – laughing and giggling in glee) in the children's play area. He removed the head set, confirmed his lunch was over, stood up lowering his phone as he did so an image of the torso of a naked lady was promptly switched of as he was in the process of doing this also.*' [sic]

The panel found that Colleague E's evidence was clear, consistent and compelling. In her evidence Colleague E demonstrated how you had lowered your phone towards her to switch it off and she was able to describe in detail what she had seen on the screen:

> '*I am fully confident on what I've seen* […] *female form unclothed, just torso* […]*, full screen* […] *I didn't see any written text.* […] *I don't know if it was a video or photo.* […]
> *I was two to three metres away when I saw the image. Could pretty much see all of the screen* […] *flesh tones* [...] *Down to the naval, torso, not pubic area, but naked head, shoulders, breasts and chest.*'

Colleague E said that, while she wore glasses for reading, her long sighted vision was very good.

The panel found that the level of detail given by Colleague E added to the credibility and reliability of her evidence.

During the Trust's disciplinary investigation, you had stated that it was an image of your sister on your phone. However, in your written representations, you said that you were checking text messages. The panel found that your evidence was inconsistent and that it had changed over time.

The panel therefore preferred Colleague E's evidence to your evidence.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 9 November 2018, you viewed an image of a naked adult female on your phone in the 'Children's Play Area'

Charge 19ii)

19. On 09 November 2018

ii) Confronted Colleague E about a medication error in a public area and/or

This charge is found proved.

In reaching this decision, the panel had regard to Colleague E's evidence, her local investigation statement, the daily assessment sheet for 9 November 2018 and to your evidence.

In her witness statement Colleague E said:

'*On the day question (9 November 2018), a patient had come in and unfortunately and error occurred whereby I administered the incorrect eye drops. After the error occurred Nino made a comment about it, I cannot remember exactly what he said, but it was essentially questioning the eye drops, this could have waited until I left the room.*

I reported the error and informed the nursing sister and the doctor about what had happened. I also apologised to the patient and submitted a datex. After I had reported the error and had apologised to the patient, Nino then brought it up in the patient waiting area, in front of colleagues and patients and said that I had given a patient the wrong eye drops and questioned what I was doing about this, despite him being aware that I had reported it, I was very upset and had apologised to the patient, this was very inappropriate. I was already upset and flustered about the error, and there was no subtlety about his questioning, it was not asked in a caring

or tactful manner, just in front of a room of people. I then pulled him into the sluice and challenged him about this and explained that he was not helping me concentrate on my work.
After this day I went to the nursing sister and stated that I could not work with Nino anymore and needed time out. ' [sic]

In your written representations you said:

'*I politely asked Colleague E a few questions about the incident. I did not confront Colleague E. I witnessed the administration of a wrong medication (a different eye medication/ not the prescribed one was accidentally/ unconsciously instilled) and I acted accordingly.'*

You confirmed this in your evidence and further said that nobody else was present during this discussion.

The panel found that Colleague E's evidence was consistent and reliable. It was clear that she took sole responsibility for the medication error, reporting and remediation. Colleague E described the effect upon her of being questioned robustly before a number of people. She said that it upset her even further than did her error alone, to the extent that she subsequently reported this incident to her manager stating that she could not work with you anymore. The panel found her description of the effect upon her to be compelling and to have been caused by the nature of your confrontational questioning while in a public area. Your account was corroborated by the entries made by a Staff Nurse in the daily assessment sheet for 9 November 2018. The panel also found that Colleague E's account was similar in nature to descriptions of your general style of communication given by other witnesses. It therefore preferred Colleague E's account to yours.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 9 November 2018, you confronted Colleague E about a medication error in a public area.

Charge 19iii)

19. On 09 November 2018

iii) Confronted Colleague E unnecessarily about the medication error as remedial action was already underway.

This charge is found proved.

In reaching this decision, the panel had regard to Colleague E's evidence, her local investigation statement, to the daily assessment sheet for 9 November 2018 and to your evidence.

The panel reminded itself of its findings with regard to charge 19 ii).

Colleague E confirmed that you had been present and had witnessed her remedial actions, namely, that she had apologised to the patient, informed the nurse and doctor on duty and that she had completed a Datix incident report of her own accord.

You said in your evidence that Colleague E had completed the Datix because you reminded her to do so. You agreed that you had been present and witnessed her remedial actions with the exception of Colleague E informing the doctor.

Colleague E was an experienced nurse who was aware of the protocol regarding errors in drug administration and took full responsibility for her error as soon as she noticed it. The panel was satisfied that you were aware that remedial action had been taken as you were present at the time of the error and during the remedial steps taken thereafter. The panel therefore preferred Colleague E's evidence, which was cogent and consistent. Your account was corroborated by the entries made by a Staff Nurse in the daily assessment sheet for 9 November 2018.

For these reasons and the reasons stated above in charge 19 ii) the panel found that you unnecessarily confronted Colleague E about a medication error when you knew that remedial action had been taken by her.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that, on 9 November 2018, you confronted Colleague E unnecessarily about the medication error as remedial action was already underway.

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, with regard to charge 19i), and a lack of competence with regard to the remaining charges, 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 and/or a lack of competence. Secondly, only if the facts found proved amount to misconduct and/or a lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct and/or lack of competence.

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.'*

Mr Underwood invited the panel to take the view that charge 19i) amounted to misconduct. He referred the panel to the 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and identified the specific, relevant standards where your actions amounted to misconduct. He submitted that viewing explicit images while on shift, in a public part of the ward, is behaviour that is likely to bring the profession into disrepute. Mr Underwood submitted that this was inappropriate behaviour which risks causing any member of the public who might witness it to lose confidence in the professionalism of nursing as a whole.

Mr Gamboa's submissions did not address the subject of misconduct.

Submissions on lack of competence

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Mr Underwood invited the panel to take the view that the facts found proved amount to a lack of competence.

Mr Underwood identified the specific, relevant standards where your actions amounted to a lack of competence.

Mr Underwood submitted that you have shown a significant lack of professional judgement in that you inappropriately laughed while working on an acute ward, were inappropriate, rude and sometimes communicated in an aggressive manner with staff, demonstrated an inability to communicate properly with patients about their care and failed to respond appropriately when patients were indicating that they were in discomfort or pain. He submitted that you also demonstrated a disregard for the health and wellbeing, whether physical or mental, of patients in your care. Further, Mr Underwood submitted that you were unable to properly prioritise tasks and identify or act on them appropriately, particularly when patients appeared to be unwell or deteriorating.

Mr Underwood submitted that you were lacking the professional judgement to practise safely and effectively as a nurse. He stated that your inappropriate behaviour would not only have affected your own performance, but would also have been difficult or distracting for other nurses and medical staff on the Ward. He reminded the panel that one of your superiors stated that you did not necessarily lack the basic nursing skills or knowledge and could demonstrate them in a training situation, but rather that you were unable to put them in to practise in the setting of an acute ward. Further, Mr Underwood submitted that even when you were moved from a stressful ward environment to a less pressurised one, your behaviour continued.

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

Mr Gamboa submitted that you did not experience the level of support that you needed to improve your practice. He suggested that the Trust, in its investigation, did not exercise a certain level of tolerance and acceptance toward you nor have your colleagues gone the ‘extra mile’ in your case.

Submissions on impairment

Mr Underwood moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and 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).

Mr Underwood submitted that there is no evidence before the panel to suggest that your behaviour has been remediated. He submitted that you have shown a distinct lack of insight into your behaviour in that you not only have denied most of the charges against you but also alleged that others on the ward behaved unprofessionally against you and that your colleagues have influenced patients to complain, demonstrating a tendency to shift blame for these incidents onto others.

Mr Underwood submitted that the Hospital acted entirely appropriately and suspended you when they first became concerned [PRIVATE], only letting you return to work under supervision [PRIVATE].

Mr Underwood submitted that your behaviour has in the past and is liable in the future to bring the medical profession into disrepute. He submitted that there is no evidence of insight or remediation on your part and that your fitness to practise is therefore impaired by reason of your lack of competence, and misconduct.

Mr Gamboa submitted that you realised your shortcomings and that you have demonstrated good insight into your failings. He informed the panel that you have not been working as a registered nurse, however, continued your professional development by taking a course in Customer Service Level 2, NVQ Level 1 Contact Centre Operations and BTEC Level 1 Work Skills. Mr Gamboa acknowledged that these do not relate to the healthcare sector, however, that you can transfer these learned skills once you return to

the nursing profession. Mr Gamboa submitted that these courses have considerably helped you to manage your behaviour towards colleagues and towards the general public. Mr Gamboa also said that, from October to December 2021, you worked as a volunteer at a Sense Charity shop, where you were sorting out donations and dealing with customers. Mr Gamboa submitted that this improved your prioritisation and management of work skills.

The panel accepted the advice of the legal assessor.

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 in charge 19i) did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

20 Uphold the reputation of your profession at all times

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that looking at a picture of a naked female on your mobile phone in a public, children's area of the hospital while on duty was highly inappropriate. The panel considered that you did not uphold the reputation of your profession or display a personal commitment to the standards of practice and behaviour set out in the Code. The panel determined that your behaviour was not demonstrating integrity and leadership for others to aspire to. It concluded that this could lead to issues with trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

The panel therefore found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on lack of competence

The panel had regard to the NMC's guidance on lack of competency, which indicates that this should be assessed using a three stage process:

- Is there evidence that you were made aware of the issues around your competence?
- Is there evidence that you were given the opportunity to improve?
- Is there evidence of further assessment?

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable average registered nurse and not by any higher or more demanding standard.

When determining whether the facts found proved amounted to a lack of competence, the panel had regard to the terms of the Code. In particular, the panel found that you had breached the following standards:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.6 recognise when people are anxious or in distress and respond compassionately and politely

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

To achieve this, you must:

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the code

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

First, the panel considered charges 16i), 17 and 18. The panel considered that these charges all related to inappropriate laughing and/or talking to yourself when working on an acute ward. The panel considered there to be enough evidence before it to demonstrate that you were aware of the issues as the inappropriate laughing and/or talking to yourself

was brought to your attention and addressed during several meetings with your line manager, the letter informing you that the Trust had launched an investigation into your behaviour as well as the investigation report. The panel concluded that you had been given a chance to improve your behaviour, however, were not able to demonstrate a change in behaviour. This was demonstrated throughout your supervision and evidenced by several entries in the daily assessment sheets. These were completed in November 2018 by colleagues from different clinics in the outpatient department. You explained in your evidence that you were just a 'smiley' person. However, the panel determined that your behaviour of laughing and/or talking to yourself at inappropriate times in an acute ward, demonstrated a lack of sensitivity and consideration towards your patients and their families as well as making your colleagues feel uncomfortable and disrespected. The panel therefore determined that there was a pattern of behaviour which resulted in a lack of competence.

The panel then considered charges 1, 3, 10ii), and 19ii) and 19iii) as they all related to an inappropriate, rude and aggressive manner of communication. The panel considered there to be enough evidence before it to demonstrate that you were aware of the issues raised with you by Colleague J and Colleague F. You acknowledged in your evidence that despite being told that your colleagues did not feel comfortable with your behaviour, you carried on shouting 'garlic' at them. There is again evidence before the panel demonstrating that this was also raised in management meetings with you, however, you either denied the allegations or you were dismissive of them. However, the panel considered that despite you being made aware of your colleagues perceiving your behaviour as inappropriate, rude, and at times aggressive, you did not take the opportunity to improve your behaviour. You continued to demonstrate this inappropriate and rude behaviour during the investigation meetings with Colleague J and Colleague F as stated in the investigation report:

> '*The meeting notes record that* [Mr Yraola] *was constantly talking over* [Colleague J] *and* [Colleague F] *during the meeting making it difficult to establish facts. These behaviours led to termination of the meeting* […] [PRIVATE]'

The panel found that any one word shouted at a person could be taken as offensive. The panel was aware that garlic has a particularly pungent odour and concluded that the manner, context and timing of you shouting “garlic” could be taken as offensive.

The panel determined that your behaviour, demonstrated a lack of sensitivity, understanding towards and respect for your colleagues and the impact your behaviour might have on them. The panel concluded that there was a pattern of behaviour which amounted to a lack of competence.

Next the panel considered charges 9, 12i), 12 iii), 12v) and 16ii) which all relate to your inability to communicate properly with patients about their care. The panel considered that there is evidence before it, in the investigation report and the daily sheets, to demonstrate that you were made aware of the issue, had been given the opportunity to improve however, failed to do so. The panel considered that, in charge 16ii), when you shouted ‘open’ at the patients, this was inappropriate, offensive, belittling and demeaning. The panel therefore concluded that there was a pattern of behaviour showing a disregard for the health and wellbeing of your patients, whether physical and psychological. It therefore considered charges 9, 12i), 12 iii), 12v) and 16ii) demonstrated a lack of competence.

The panel then considered charges 2, 5i), 5iii), 6, 7vi), 8, 10i), 11, 14 and 16iii) which related to a failure to respond appropriately when patients were indicating they were in discomfort or pain, showing a disregard for their health or wellbeing, your inability to prioritise tasks and act promptly and appropriately, particularly when a patient appeared to be very unwell or deteriorating. The panel again considered there to be enough evidence before it, including the investigation report and documentation of meetings with your manager, demonstrating that you had been made aware of the issues with your practice, however, continued to demonstrate poor judgement and a lack of concern for your patient’s welfare. The panel found evidence supporting that these concerns were raised with you in April/May 2018, however, your behaviour still continued in August 2018. The panel noted that you continued to blame others for your failings and deflected responsibility. It considered that you did receive training on how to escalate deteriorating

patients and that concerns were raised with you by the senior nurse from the critical care outreach team, yet you continued to state that you were unaware of the procedure of the escalation process. The panel therefore concluded that there was a pattern of behaviour showing a disregard for the health and wellbeing of your patients, an inability to prioritise tasks and take prompt and appropriate actions when patients appeared to be unwell and/or deteriorating. It therefore considered charges 2, 5i), 5iii), 6, 7vi), 8, 10i), 11, 14 and 16iii) demonstrated a lack of competence.

The panel then considered charges 3i), 12 ii), 13 and 15. It concluded that these charges were single instances of occurrences that were not repeated, for example that you were you were running late to your shift. These only occurred once and there was no evidence before the panel that you had repeated the facts found proved in these specific charges. Therefore, the panel did not consider that these charges demonstrated a pattern of conduct and concluded that these individual charges did not amount to a lack of competence.

Taking into account the above and the reasons given by the panel for the findings of the facts, the panel has concluded that during the period between November 2017 and July 2019 your practice repeatedly and persistently demonstrated poor judgement and was below the expected standard of competence for a registered nurse. In all the circumstances, the panel determined that your practice demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of your misconduct and the lack of competence, 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 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 *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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; and/or*

d) […]*'*

The panel found that with regard to your misconduct relating to charge 19i), limbs b) and c) were engaged, and that this breached a fundamental tenet of the nursing profession and brought its reputation into disrepute.

It further concluded that your lack of competence could, as it did, put patients at risk.

It was submitted on your behalf that you did not experience from the Trust, or from your colleagues, the level of support necessary to improve your practice.

The panel did consider, whether there were any factors external to and independent of you, which were relevant to the matters found proved. However, the panel found that you had undergone all relevant training and induction together with comprehensive and supportive intervention designed to address behavioural and clinical issues. This included an action plan and supervision focussing on professional and clinical matters. Furthermore, the panel was satisfied from the investigation report that there were no matters of culture or race which could indicate professional isolation as being in any way relevant to the concerns about your practice.

The panel therefore found nothing to indicate that there were any factors, independent of your personality or behaviour that were relevant to the standard of your professional performance.

Regarding insight, the panel considered that you demonstrated a lack of insight into your misconduct and your lack of competence. The panel noted the investigation report which stated:

> *'The investigation could find no evidence that past concerns and behaviours had been recognised, appreciated or addressed* [by him]*.* [Mr Yraola]*'s main response to the concerns raised have been primarily concerned with his own right of individuality and to be himself rather than the impact on patients or colleagues.*

[…]

The investigation notes the discussion which took place in an assessment meeting with Sister [Colleague H] *and matron* [Colleague J] […] *whereby* [Mr Yraola] *had self-assessed himself as high performing in all areas of the professional assessment grid but* [Colleague H] *and* [Colleague J] *challenged this assessment.* [Mr Yraola]*'s response was noted to be dismissive of other's opinions and his response was noted in that he 'shrugged his shoulders and stated that this is my opinion and that is your opinion*

[…]

The issues and concerns are compounded in that [Mr Yraola] *has failed to recognise his own limitations and has demonstrated very little self-awareness/insight or acknowledgement into the concerns raised and discussed with him on multiple occasions. The investigation has cited instances where* [Mr Yraola] *dismisses or denies any 'unfavourable feedback' and could not find effort or attempt to change or modify his behaviours. There is no evidence to show that* [Mr Yraola] *has reflected himself and accepted his own role and responsibility into what may have gone wrong.* [Mr Yraola] *repeatedly expresses his opinion that he is being denied the opportunity to be himself and the actions which are intended to support him are perceived by* [Mr Yraola] *as attempts to control and manipulate him.'.*'

The panel considered your evidence at the hearing as well as your written representations and concluded that your insight had not developed much since the investigatory interview. The panel concluded that your responses were mainly self-centred, deflective, did not demonstrate insight into the welfare, psychological and emotional needs of your patients nor any insight into what effect your past behaviour had on your colleagues, your patients, their families and the profession as a whole. The panel did not have any evidence before it that you understand why your behaviour was inappropriate and misplaced or how you could prevent it happening again in the future.

The panel considered whether your lack of competence was remediable. It had particular regard to the NMC guidance on Lack of Competence, defined as:

> '*An unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance, when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.*'

The panel considered that the underlying issues in this case relate to a significant, repeated and persisting lack of judgement in nursing practice. The panel found that based on a fair sample of work, an unacceptably low standard of professional judgement was evident. The panel determined that this impacted on clinical decision making and professional interactions with colleagues and patients. The panel determined, that given the foregoing, this lack of competence was not easily remediable.

In its consideration of whether you have taken steps to strengthen and remediate your practice, the panel took into account your evidence and the three training courses you attended in relation to customer service, contact centres and work skills. Further, it considered that whilst you had taken the training courses there was no evidence of these courses having assessments within them and therefore, no evidence of learning having in fact taken place, rather that you merely attended the courses. In addition, there was no evidence regarding how you have applied, or would apply any learning in practice. While the panel acknowledged that you have not been working as a registered nurse, it was aware that you had not applied for any other role within a health or care setting. It did not have any evidence before it that you were able to strengthen your professional behaviour within other settings. Furthermore, you have continued to seek to blame others and deflect from your responsibility to work within a team.

The panel determined that there was no objective evidence before it that you have remediated your practice relating to your misconduct and incompetence. The panel is of the view that there is a high risk of repetition based on the lack of insight and the lack of

remediation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

In addition, 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 by reason of your misconduct and your lack of competence.

Sanction

The panel has considered this case and has decided to make a suspension order for a period of 12 months with a review. The effect of this order is that the NMC register will show that your registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Underwood outlined the aggravating and mitigating features of this case. He submitted that your conduct was repeated over a long period of time and despite this being brought to your attention you failed to correct your behaviour and are still failing to recognise how

your behaviour was unprofessional. He submitted that in relation to your misconduct in charge 19i) mitigating features were that it was a single incident of misconduct with no patient present and only one staff member witnessing it; further, that your misconduct had not been repeated.

Mr Underwood submitted that taking no action or a caution order would not be sufficient to protect the public or address the public interest.

Mr Underwood reminded the panel that a striking off order is not available to the panel in relation to the lack of competence and only in relation to the misconduct charge. However he submitted that the misconduct in charge 19i) was not serious enough to warrant a striking off order nor is it incompatible with remaining on the register. He therefore submitted that a striking off order would be disproportionate.

Mr Underwood submitted that, since 21 August 2019, you had been subject to an interim suspension order and had not had the opportunity to practise your nursing skills. He submitted that based on the panel's finding on facts you would require onerous conditions, in that you would need to be supervised directly until being signed off by your employer, which would be unworkable. He submitted that further, such a condition would also not be sufficient as you have worked supernumerary previously, where your behaviour was supervised, however failed to improve your behaviour and repeated it with a disregard for others and how your behaviour affected them. He submitted that you repeatedly failed to modify your behaviour despite this being brought to your attention by colleagues and senior staff and have, during this hearing, shown little to no desire to change your behaviour. Mr Underwood submitted that you have shown little appreciation in how your behaviour is not appropriate within the healthcare environment. He therefore submitted that, until you gained insight into your behaviour, there is a continued risk to patients even if you were allowed to practice with stringent conditions in place.

Mr Underwood therefore submitted that the appropriate and proportionate order under the circumstances is a suspension order, imposed for a period of 12 months, with a review.

Mr Underwood submitted that, should the panel not be with him on this, then stringent conditions, including supervision, a Personal Development Plan (PDP) and the restriction of working outside a hospital ward setting would be necessary.

Mr Gamboa agreed with Mr Underwood that the misconduct found proved was a single incident which had not caused patient harm and was at the 'bottom of the scale' of seriousness.

Mr Gamboa reminded the panel that as you were restricted from working as a registered nurse this may have restrained you from remediating your practice and gaining insight to your behaviour.

Mr Gamboa did not make submissions regarding any particular sanction.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Your lack of insight;
- You demonstrated a pattern of conduct of lack of competence over 22 months;
- Your conduct put patients at a risk of harm;
- You showed indifference to how your behaviour affected patients, their families, your colleagues and the public perception of the nursing profession.

The panel also took into account the following mitigating features:

- You admitted some of the charges early in the NMC proceedings; and
- With regard to 19i), the misconduct charge, it was a single incident which did not put patients at a risk of harm and was only witnessed by one other member of staff.

The panel considered the aggravating features to outweigh the mitigating features.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of your lack of competence and the prolonged pattern of behaviour which was not addressed despite being pointed out to you. The panel decided that it would be neither proportionate nor in the public interest to take no further action. Lack of competence of this nature requires a sanction.

It then considered the imposition of a caution order but again determined that, due to the seriousness of your lack of competence, the public protection issues identified and the lack of insight, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG.

However, with regard to your lack of competence, the panel determined that your behaviour and the lack of judgement you have demonstrated persistently and repeatedly in your behaviour towards patients and colleagues, as well as the lack of insight on how your behaviour affected patients and colleagues, suggest that there are attitudinal problems that need to be addressed. The panel considered that there are identifiable areas in your clinical practice that might be addressed through retraining. However, it also considered that you have demonstrated that you were not receptive to feedback nor responded positively to it when raised with you by your colleagues and superiors.

The panel had particular regard to Colleague D's record of the meeting with you on 24 August 2018:

> '*You informed me* [Colleague D] *that you had completed the self-assessment of the professional grid and that you felt that you were fully performing in all aspects that this identifies.*
> *Matron* [Colleague J] *also gave feedback on this assessment and raised a disparity between your self-assessment and the assessment of your peers, colleagues and assessors. You replied that it is 'your opinion' and 'their opinion' and that you felt that you are fully performing in all the identified areas.*'

It determined that your lack of acceptance of your poor practice and your attitudinal and behavioural issues can only be addressed though deep reflection, a willingness on your part to work on these issues and gain insight into why your behaviour was inappropriate. The panel took into account that, despite receiving comprehensive and extensive support over a period of time, you failed to correct your behaviour. The panel was of the view that until you have gained insight into your behaviour, patients will be put at a real risk of harm even if you were allowed to practice under close supervision. The panel therefore determined that there are no conditions which would be workable, appropriate or sufficient in the light of the serious nature of your lack of competence.

Further, the panel determined that the misconduct identified in this case was not something that can be addressed through retraining.

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

With regard to the above, the panel concluded that patients were put at risk of significant harm because of your lack of competence. It considered that the charges found proved occurred predominantly whilst you worked under supervision, yet you still behaved unprofessionally, roughly handling patients and shouting at them, knowing that you were being observed. The panel was of the view that, had your colleagues not intervened, your acts and omissions may have placed patients at even greater risk of harm.

As a striking off order was not available with regard to lack of competence, the panel considered it only with regard to misconduct. The panel was satisfied that your misconduct was not fundamentally incompatible with remaining on the register as it was a single incident, on the lower end of the spectrum of seriousness, which did not involve patient safety.

Balancing all these factors, and given your lack of insight and the high risk of repetition of your behaviour the panel determined that a suspension order was the only appropriate and proportionate sanction sufficient to protect the public.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months with a review was appropriate. The panel was of the view that you needed a considerable amount of time to come to terms with your lack of competence, develop insight into this and evidence a sustained new pattern of professional conduct, preferably in a healthcare setting. The

panel considered that you need to demonstrate that you are able to uphold the reputation of the profession at all times, including:

- making as your first priority the people using or needing nursing services;
- making it your concern to ensure their care, safety and the preservation of their dignity your concern; and
- making sure their needs are assessed, recognised and responded to promptly.

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

Any future panel reviewing this case would be assisted by:

- An up to date detailed reflective piece drafted with the assistance of a model such as Gibbs (examples of which can be found on the NMC website) addressing your behaviour, its impact on patients, colleagues, the public and the reputation of the profession; and what you learned from it, taking responsibility for your own actions, not seeking to blame others, setting out a planned way forward, making changes to your nursing practice and implementing them;
- Evidence of up to date training, including any assessments by other professionals about your progress on such courses; and
- Current testimonials and references from any paid and unpaid work (preferably in a healthcare setting). These should include reference to your attitude and demeanour towards others.

This will be confirmed to you in writing.

Submissions on interim order

The panel took account of the submissions made by Mr Underwood. He submitted that an interim order is necessary to protect the public and that it is otherwise in the public interest, for the reasons identified by the panel earlier in their determination until the

suspension order comes into effect. He therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period until an appeal is determined.

Mr Gamboa did not object to Mr Underwood's submissions.

The panel heard and accepted the advice of the Legal Assessor.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period until an appeal is determined.

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

That concludes this determination.