Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday 14 November 2022
–
Monday 21 – Thursday 24 November 2022

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Mr Guilberto M Villegas Jr
NMC PIN:	01B1330O
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nursing (level 1) – 8 February 2001
Relevant Location:	Portsmouth
Type of case:	Misconduct
Panel members:	John Kelly (Chair, Lay member) Melanie Lumbers (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Chantel Akintunde (14 November 2022) Monsur Ali (15 - 24 November 2022)
Nursing and Midwifery Council:	Represented by George Hugh-Jones K.C, Case Presenter
Mr Villegas:	Not present and unrepresented at the hearing
Facts proved:	Charges 1a, 1b, 1c, 3a, 3b, 4a, 4b and 4c
Facts not proved:	Charge 2
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Villegas was not in attendance and that the Notice of Hearing letter had been sent to Mr Villegas's registered email address on 3 October 2022. The panel had regard to the email evidence and a signed statement from an NMC case officer confirming this.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and venue of the hearing and, amongst other things, information about Mr Villegas's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Villegas

The panel next considered whether it should proceed in the absence of Mr Villegas. It had regard to Rule 21 and heard the submissions of Mr Hugh-Jones who invited the panel to continue in the absence of Mr Villegas.

Mr Hugh-Jones submitted that Mr Villegas has voluntarily absented himself. He referred to the telephone conversation between Mr Villegas and an NMC case officer on 5 April 2022 which indicates his reluctance to complete and return the case management form. Following this, a further conversation took place with Mr Villegas on 7 April 2022 during

which he promised to return the forms that afternoon. Further attempts were made to contact Mr Villegas via email and telephone to no avail.

Mr Hugh-Jones submitted that Mr Villegas's engagement with the NMC in relation to these proceedings has decreased to the point of non-engagement and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

The panel decided to proceed in the absence of Mr Villegas. In reaching this decision, the panel considered the submissions of Mr Hugh-Jones and the advice of the legal assessor. It had particular regard to the overall interests of justice and fairness to all parties. It noted that:

- An application for adjournment has not been made by Mr Villegas;
- Mr Villegas has not engaged with the NMC since April 2022 and has not responded to any of the letters sent to him about date and time of this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- 5 witnesses are due to give oral evidence during this hearing;
- Not proceeding may inconvenience the witnesses, their employers and the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses to recall events accurately; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Villegas in proceeding in his absence. Although the evidence upon which the NMC relies has been sent to him at his registered email address, he has not made a formal response to the allegations. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. The limited disadvantage is the consequence of Mr Villegas's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Villegas. The panel will draw no adverse inference from Mr Villegas's absence.

Details of charge

'That you, a Registered Nurse:

1. On 30 June 2020 allowed Student Nurse A to carry out the following tasks when they were not appropriately trained and/or permitted to carry out those tasks:

a) disconnect Patient B from haemodialysis.

b) administer intravenous saline and/or DuraLock through a central venous tunnel line to Patient B.

c) Cap off the lumen for Patient B.

2. On or around 24 July 2020 breached patient confidentiality by naming a patient on a closed Facebook chat group with colleagues.

3. Made the following comments about patients on a closed Facebook chat group with colleagues which are inappropriate and/or derogatory:

a) "cub in rdu has a shitty bum every few minutes"

b) "…bed two is barking mad".

4. On 28 July 2020:

a) Prescribed haemodialysis to Patient A when you were not qualified to do so.

b) Initiated haemodialysis to Patient A when you knew there was no valid prescription in place.

c) Did not follow Patient A's medical plan of care.

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

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account the oral and documentary evidence in this case, together with the submissions made by Mr Hugh-Jones on behalf of the NMC.

The panel did not draw any adverse inferences from the non-attendance of Mr Villegas. The panel recognised that this has no bearing on the burden of proof, which rests on the NMC.

The panel noted that it did not have the benefit of sight of a pre-hearing form or written submissions on behalf of Mr Villegas in considering the facts. However, the panel did have sight of a bundle of documents, paginated from 575 to 598, consisting of emails between locum recruitment agencies, course certificates obtained by Mr Villegas and his responses to the regulatory concerns signed by him and dated July 2021.

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

- Witness 1: Ward Sister for Ward G9 at Queen Alexandra Hospital during June and July 2020
- Witness 2: Second year Student Nurse on placement at Queen Alexandra Hospital on 30 June 2020
- Witness 3: Newly qualified Band 5 Nurse at Queen Alexandra Hospital on 28 July 2020
- Witness 4: Advanced Nurse Practitioner (ANP) at Queen Alexandra Hospital on 28 July 2020
- Witness 5 Experienced Band 5 Nurse at Queen Alexandra Hospital on 28 July 2020

Background

The charges arose whilst Mr Villegas was employed as a registered Band 6 senior staff nurse by Portsmouth NHS Trust (the Trust).

On 30 June 2020, Mr Villegas allegedly allowed a student nurse to disconnect Patient B from haemodialysis, administer intravenous normal saline and DuraLock through a central venous tunnel line and cap off the lumen. It is alleged that Mr Villegas also permitted the student nurse to complete the procedure when they were not trained to do so in clean personal protective equipment (PPE), rather than sterile PPE, thus breaching infection control policies and the standard operating procedures (SOP).

On 24 July 2020, Mr Villegas allegedly made inappropriate and/or derogatory comments in a closed Facebook chat group about two patients, and breached patient confidentiality by naming a patient.

On 28 July 2020, despite not holding a prescribing qualification, Mr Villegas allegedly prescribed and initiated haemodialysis for Patient A, who was suffering from an acute kidney injury (AKI). Patient A's medical plan, written the previous day, stated that his renal function and urine output was improving, and dialysis would only be required pending blood results and worsening figures. Patient A's notes specifically stated haemodialysis should only be considered after a medical review of further blood results.

The Trust undertook an investigation and a disciplinary hearing was held on 15 September 2020.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1:

1. On 30 June 2020 allowed Student Nurse A to carry out the following tasks when they were not appropriately trained and/or permitted to carry out those tasks:

a) disconnect Patient B from haemodialysis.

b) administer intravenous saline and/or DuraLock through a central venous tunnel line to Patient B.

c) Cap off the lumen for Patient B.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account all the evidence before it, including the oral evidence of the witnesses, the submissions made by Mr Hugh-Jones and Mr Villegas's responses to the regulatory concerns.

The panel first considered whether Mr Villegas allowed Student Nurse A to carry out the above tasks. The panel took into account the evidence of Witness 2, (Student Nurse A) who confirmed during her oral evidence that Mr Villegas permitted her to carry out the tasks listed in charge 1a, 1b and 1c, which was consistent with her local statement, written within 24 hours of the incidents and her statement to the NMC, dated 26 May 2021 in which she stated:

> *'Patient B was lying in their bed and the dialysis machine was on the left side. The Nurse was standing next to the machine and inches away from Patient B. I was leaning over the chest of Patient B whilst the Nurse instructed me of the steps required to take Patient B off the dialysis. I was supervised very closely. Whilst I dealt with disconnecting Patient B, the Nurse took responsibility for operating the machinery as this needed to be managed whilst disconnecting. I disconnected the central venous tunnel line from Patient B and flushed them with normal saline, I also had an alcoholic wipe and was instructed by the Nurse to clean entry lines from the clamp to reduce the chance of infection. I then flushed all the ports with normal saline and cleaned them with the alcoholic wipe between flushes. I remember this very well because the Nurse reminded me very clearly of the importance of the alcoholic wipe. After this, I flushed the lines with Duralock [sic] and put the caps back on the lumen to keep them clean. The procedure took around 15 minutes.'*

The panel took into account the evidence of Witness 5 who stated in her written statement and confirmed during her oral evidence that she saw the student nurse apparently either having disconnected Patient B from Haemodialysis or in the process of doing so. The panel also took into account the evidence of Witness 1 who stated that the student nurse confirmed to her that Mr Villegas had asked whether she wanted to disconnect Patient B from haemodialysis, which she agreed to do, and administered

intravenous normal saline and DuraLock through Patient B's central venous tunnel line and capped off the lumen.

The panel also accepted the evidence of Witness 5 who described how, having been alerted by dialysis machine alarm, she went to the bedside of Patient B and saw Mr Villegas standing by the dialysis machine and Witness 2 (Student Nurse A) standing on the opposite side of the bed, apparently in the course of or having completed a disconnection of Patient B from dialysis. Witness 5 gave evidence that she challenged Mr Villegas by saying *"what are you doing?"* to which he replied *"I am just showing her*". Witness 5 noted that Witness 2 *'was bent over Patient B and it looked like they were or had been doing something with Patient B's haemodialysis access, which students are not clinically permitted to do.'* Consequently, Witness 5 further challenged Mr Villegas by saying *"no you are not showing her, she is doing it".* Witness 5 stated that Mr Villegas did not respond. Soon after, Witness 5 approached Witness 2 to ask what she had been doing and Witness 2 confirmed that she had administered normal saline and DuraLock through the central venous tunnel line of Patient B.

The panel also accepted the evidence of Witness 1 who gave oral and written evidence that Witness 5 reported the matter to her soon after on the day and that Witness 1 spoke with Witness 2 in her office. Witness 1 stated that Witness 2 confirmed that Mr Villegas had *'asked whether they wanted to disconnect Patient B from haemodialysis, which they agreed to, and administered intravenous normal saline and the DuraLock through Patient B's central venous tunnel line and capped off the lumen.'*

Witness 1 provided evidence that she then spoke to Mr Villegas who initially denied allowing Witness 2 to disconnect Patient B's dialysis, claiming to have shown Witness 2 what to do as a learning experience. When, however, he was confronted by the witness evidence, Mr Villegas acknowledged that he had talked Witness 2 through the procedure whilst he watched.

The panel noted that in his response to the regulatory concerns, Mr Villegas again denied that he had allowed Witness 2 to carry out the tasks relating to the disconnection of Patient B from haemodialysis, saying:

‘a final year student… she wanted to assist I have to discuss and show it to her how to take patient from HD [haemodialysis] using aseptic technique.’

‘Never would instruct someone not to follow the infection control practices in the times of epidemic especially on a transplant ward.’

The panel also noted the following extract from the Trust’s Medicines Management policy:

‘avoid any improper delegation to others, which compromises the interests, wellbeing or safety of patients and clients.’

Having regard to this evidence, the panel determined that Mr Villegas allowed Student Nurse A to carry out the tasks at a, b and c of charge 1.

The panel next considered whether Student Nurse A (Witness 2) was appropriately trained and/or permitted to carry out the tasks. At the time of the incident, she was a second year student nurse, on placement on Ward G9 at the Trust.

The panel took into account the following extracts from the Trust’s Medicine Management policy when making its decision:

‘Student nurses may observe the administration of medicines and assist in the administration of medicines by the following routes under the direct and constant supervision of a qualified nurse, midwife or medical practitioner. NB. This does not apply to student nurses on Critical Care who cannot prepare or administer any medications.

• oral…

Students may not participate in the administration of medicines by the following routes:

• intravenous lines (see below for IV fluids)

• peripheral lines/ central lines

…

As an exception students may administer prescribed pre-prepared standard IV bags of 0.9% of sodium chloride, 5% glucose or compound sodium lactate (Hartmann's solution) via an existing intravenous or subcutaneous line.'

Further, the panel noted the following extract from the Patient Specific Direction relating to the medical device DuraLock:

'The qualification required to deliver this is that the qualified nurse employed to work at Wessex Kidney Centre who has current NMC registration.'

'The registered professional is accountable for ensuring that all non-registered practitioners to whom administration of medications is delegated have received training and been assessed as competent.'

Witnesses 1, 2 and 5 confirmed in evidence their understanding that student nurses are not allowed to administer intravenous medication, nor disconnect patients from dialysis. Having regard to this body of Trust policy and witness evidence, both oral and written, the panel concluded that Witness 2 was not permitted to carry out the tasks subject of charge 1a, b and c.

Having concluded this, the panel considered the training required to allow a nurse to undertake the tasks in charge 1a, b and c, regardless of the fact that, as a student nurse, Witness 2 was not permitted to carry them out. Witnesses 1 and 5 both confirmed that the training needed to become competent in carrying out the tasks subject of charge 1 would not be offered until a nurse became qualified and registered. Witness 2 herself confirmed that she had not been trained in the procedure of disconnecting a patient from dialysis.

The panel had regard to the Patient Specific Directions relating to DuraLock which sets out the specific specialist qualification required for using this medical device.

'the post registration study relevant to specialty and evidence of previous demonstrable competence in administering medication/solution via both a temporary and permanent vascular access catheter.

Completion of the inhouse competency based training WKC Staff Development Programme… including the associated competencies and competent in following WKC Standard Operating Procedure for the Management of Central Venous Catheters.'

Mr Villegas was a Senior Band 6 nurse, with 20 years' experience in the UK and regularly acted as nurse in charge. When spoken to on the day of the incident by Witness 1, Mr Villegas denied knowledge of the policy prohibiting student nurses carrying the tasks subject of charge 1. He later, during the Trust investigation, admitted that he knew of the policy and denied that Witness 1 had been allowed to carry out the tasks, claiming that she had observed him disconnecting Patient B from haemodialysis.

The panel also noted that later, during the Trust investigation interview that took place on 15 September 2020, Mr Villegas, again asserted that he had carried out the procedure to remove Patient B from haemodialysis himself, with Witness 2 watching and asking questions. He added that when asked by Witness 2 if she could help in the procedure, he said no. He also denied having acknowledged that Witness 2 performed the intervention and said that she was *'confused what she should or should not do'.*

Having regard to Mr Villegas's experience as a nurse, the panel considered it implausible that he was not aware of the restriction in Trust policy on student nurses carrying the tasks subject of charge 1. Indeed, having originally denied being aware when spoken to by Witness 1 on the day of the incident, Mr Villegas later, at the Trust investigation accepted that he knew of the policy. The panel noted that other members of the staff of Ward G9 who were junior to Mr Villegas were fully aware of the policy.

The panel found Witness 1, Witness 2 and Witness 5 credible, reliable and they were broadly consistent with each other. The panel had regard to Mr Villegas's response to the regulatory concerns and his answers to Trust investigation interview. However, it

afforded these very little weight since they were untested by cross examination and were inconsistent with the answers given when initially questioned by Witness 1. The panel took account of the fact that Witness 1 made a record of this meeting on the same day whilst the matter was fresh in her memory.

Having considered all the evidence, the panel determined that Mr Villegas did allow Student Nurse A to carry out the three tasks listed in charge 1. The panel therefore found charge 1 proved in its entirety.

Charge 2:

> *2. On or around 24 July 2020 breached patient confidentiality by naming a patient on a closed Facebook chat group with colleagues.*

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it, including the oral evidence of witnesses and the submissions of Mr Hugh-Jones.

The panel noted that the Facebook chat group was set up for the group members of the ward and it was a closed chat group. In one passage of messages, a comment was posted that named a patient along with mention of the potential for him to be moved to another ward. Witness 1 gave oral evidence that on accessing the chat group, she recognised the person responsible for the post was the registrant whom she recognised from his thumbnail photograph appearing with the post.

The panel took into account the decision in the case of *Saha v General Medical Council* [2009] EWHC 1907 (Admin, which states:

> *'medical confidentiality is not an absolute right, but necessarily involves a balancing of competing public interest. The public interest in patient safety and welfare is an extremely important consideration. A further highly relevant consideration is the person to whom the disclosure has taken place or is*

envisaged: disclosure to a person who is aware of the confidentiality and who has a role in its consideration or evaluation is to be distinguished from general disclosure or publication'.

The panel took the view that members of the chat group would have been aware of the need for confidentiality around information posted and that the post did not include confidential medical information. Whilst this type of media is not an appropriate means of communicating work-related information, having reviewed the information posted in the group chat and considered the potential audience, the panel was of the view that members of the group would, as a consequence of their work on the ward, have already been aware of the name posted. The panel therefore determined that posting this patient's name could not in all the circumstances amount to a breach of patient confidentiality and this charge is therefore, not proved.

Charge 3:

3. Made the following comments about patients on a closed Facebook chat group with colleagues which are inappropriate and/or derogatory:

a) "cub in rdu has a shitty bum every few minutes"

b) "…bed two is barking mad".

This charge is found proved in its entirety.

In reaching this decision, the panel took into account all the evidence before it. In particular, it took into account of Witness 1's written statement and oral evidence, along with oral evidence from Witness 3. The panel also had regard to Mr Villegas's responses to the regulatory concerns, dated 5 July 2021.

The panel noted that the alleged comments subject of charge 3 were found in the same passage of chat messages that were the subject of Charge 2 above. Witness 1 gave oral evidence that, on accessing the chat group, she recognised the person responsible for the posts containing these comments as being the registrant, again whom she

recognised from his thumbnail photograph appearing with the posts. Consequently, the panel found that the posts were made by the registrant.

During the HR Investigation conducted by the Trust, the registrant was recorded as saying that the comments were *'street talk'*, *'funny'*, *'not derogatory'* and '*not offensive'.* He added that English was not his first language.

During oral and in her written evidence, Witness 1 described the messages as consisting of '*derogatory language about patients'* and further agreed that they were derogatory in oral evidence. Witness 1, in her written statement to the NMC, dated 5 July 2021, went on to say:

> *'The Nurse said that the messages they sent on 24 July 2020 were funny and not derogatory, the Nurse reported that he had heard this type of language used before and thought it was acceptable English is not the Nurse's first language. The Nurse apologised.'*

Witness 3 described the comments as *'awful'* and '*not professional'* during her oral evidence and added that such language was not commonly used. All witnesses agreed that Mr Villegas's use of English language was fluent and they experienced no difficulties understanding him.

In his response to the regulatory concerns, Mr Villegas said that the word [sic] *'barking mad'* was a term used at the handover to describe a very confused/aggressive patient. He added that he is used to the meaning that is synonymous to aggressive confused behaviour. He added that the term *'runny bottom'* was used to describe incontinence of loose stools. The panel noted that Mr Villegas's reference to the term *'runny bottom'* is at odds with the term *'shitty bum'* subject of charge 3a and as appears in the screenshot of text messages.

The panel accepted the Legal Assessor's advice that *'inappropriate'* should be interpreted as *'not proper or suitable in the circumstances'* and *'derogatory'* as *'critical or displaying a disrespectful attitude in the circumstances'.*

The panel noted that these comments did not include any medical or therapeutic information about the patients referred to, nor could they be described as helpful to the patients. Also, the information given in the messages was capable of identifying the individual patients about whom these remarks were made to other ward staff. The panel noted Mr Villegas's apology made at the time of the Trust investigation.

In all the circumstances, the panel finds that these comments were both inappropriate and derogatory. Consequently, Charge 3 is found proved in its entirety.

Charge 4.a):

> *4. On 28 July 2020:*
>
> *a) Prescribed haemodialysis to Patient A when you were not qualified to do so.*

This charge is found proved.

In reaching this decision, the panel accepted the evidence of Witness 1, Witness 3 and Witness 4 and found it to be credible, reliable and consistent.

Mr Villegas was on duty with Witness 3 who had been allocated Patient A as her responsibility at the start of the shift. She was aware from handover and documentation that Patient A was an acute kidney injury patient. Several witnesses including Witness 4 confirmed that acute patients require daily prescriptions for dialysis, issued only after blood tests and medical review to determine the continuing need or otherwise for dialysis. Chronic patients, however, are issued regular prescriptions for their continuing treatment. In addition, Patient A's medical notes from 27 July 2020 show a detailed plan of care documented at 14:20 by ANP Witness 4 which sets out that Patient A would only be considered for further dialysis following medical review and assessment of blood results.

The panel had sight of an acute dialysis pathway prescription for Patient A dated 28 July 2020. During oral evidence, Witness 4 told the panel that the top one-third of this form is the actual prescription for dialysis. Whilst the prescription is not signed by a doctor or other person duly authorised, the panel noted that significant elements of the prescription had been completed.

Witness 3 stated in oral evidence that she recognised the handwriting on the prescription as being that of Mr Villegas because she had worked with him since 2014. She said that she also recognised the writing on the bottom two-thirds of the form – the dialysis pathway – as also being that of Mr Villegas. Witness 4 said that he was approached by Mr Villegas with a request to sign the prescription and Witness 4 concluded that the prescription had been completed by Mr Villegas. Witness 1 stated that she recognised two sets of handwriting on the prescription of dialysis pathway form; one she recognised as that of Witness 3 and the other as that of Mr Villegas.

The panel had sight of a copy of Patient A's acute dialysis pathway prescription and noted that Mr Villegas had put his signature on the prescription pathway portion of the form and also filled in parts of the haemodialysis prescription towards the top. However, given that the unsigned prescription was put into effect and haemodialysis initiated, together with his failure to seek formal approval from someone duly qualified for one and a quarter hours, indicates that, in a real sense, he did prescribe haemodialysis to Patient A.

In his responses to the regulatory concerns date 5 July 2021, Mr Villegas denied exceeding the scope of his practice. He said that he was the nurse in charge that day and *'didn't prescribed [sic] haemodialysis to anybody,'* he added that he was only called when the machine alarmed, to troubleshoot it. He continued:

> *'my staff didn't put any name who started it on due to internet documentation so that anybody could see the updated [illegible] of that certain patient. I put my name as the one who ended it and put it on Proton (intranet).'*

The panel considered the possibility that, by completing the form, Mr Villegas's acts were merely preparatory to a later authorisation. However, given the initiation of haemodialysis that took place and that it ran for a period of one hour and fifteen minutes before being discontinued on the instructions of Witness 4, the panel determined that the act of completing the prescription was equivalent to prescribing.

The panel accepted the evidence of Witnesses 1, 3 and 4 that Mr Villegas did not have a prescribing qualification that would allow him to prescribe dialysis. During the Trust investigation, when asked if he held a prescribing qualification, Mr Villegas accepted that he did not. The panel noted that Mr Villegas does not hold a prescribing qualification on the NMC register. The panel had regard to Mr Villegas's response to the regulatory concerns and his answers to Trust investigation interview. However, it afforded these very little weight since they were untested by cross examination and were inconsistent with the answers given by other witnesses.

The panel therefore determined that charge 4a is found proved.

Charge 4.b):

4. On 28 July 2020:

b) Initiated haemodialysis to Patient A when you knew there was no valid prescription in place.

This charge is found proved.

The panel accepted the evidence of Witness 3 that Mr Villegas was the senior nurse in charge of the shift on 28 July 2020 which indicates he would have been present at the morning handover when Patient A's ongoing medical condition would have been discussed. Further, Patient A's medical notes contained full details of his ongoing plan of care written by Witness 4 the previous day which stated *'for possible dialysis tomorrow pending blood results.'* Based on the above the panel drew a reasonable inference that Mr Villegas would have known of Patient A's medical position and the plan for his care.

The panel took into account the evidence of Witness 4. He told the panel during oral evidence that he admonished Mr Villegas for initiating haemodialysis when it was not needed and in his evidence he pointed out that he had written the plan of care the day before. Witness 4 told the panel that Mr Villegas apologised to him for initiating the dialysis.

The panel therefore determined that Mr Villegas would have known that there was not a valid prescription in place for dialysis for Patient A.

Witness 3 provided evidence that she was allocated the care of Patient A on 28 July 2020 and Mr Villegas was the nurse in charge. Witness 3 told the panel in her oral evidence that she was fully aware of the plan of care for Patient A, having attended the handover and seen the plan documented the previous day by Witness 4. The panel accepted Witness 3's evidence that, having attended to Patient A including dispensing daily medication, she went to deal with a second patient, returning to Patient A between 30 and 45 minutes later. On return, she saw Mr Villegas close by Patient A and saw that Patient A had been connected to and commenced on dialysis.

Witness 4 gave oral evidence that he was on duty on the morning of 28 July 2020, but away from Ward G9 when he was approached by Mr Villegas who was in possession of the partly completed dialysis prescription form. Mr Villegas asked Witness 4 to complete the form by signing and authorising the prescription. Based on the care plan that he had documented in Patient A's medical notes the day before, Witness 4 refused to do so. He told the panel that he was annoyed that he had been asked to prescribe dialysis contrary to the medical plan. He noted that, by that time dialysis had been in place for Patient A for one and a quarter hours. Witness 4 then gave instructions for dialysis to be stopped.

The panel heard evidence from Witness 3 who confirmed that the person commencing the dialysis completes the relevant forms. The panel had sight of the completed dialysis pathway prescription which contained Mr Villegas's signature and the vital record which was generated by his personal login.

The panel noted that Mr Villegas, at the Trust investigation meeting, denied that he had initiated the dialysis procedure for Patient A on 28 July 2020. In addition, although not expressly denying initiating haemodialysis for Patient A, Mr Villegas's responses to the regulatory concerns, dated 5 July 2021, strongly imply that somebody else was responsible for initiation.

The panel noted that only Mr Villegas's handwriting was present on the prescription section of the dialysis pathway. Taking this together with the evidence of Witness 3 and 4, the panel concluded that it was not plausible that somebody else had initiated the dialysis procedure. The panel therefore determined that charge 4b is found proved.

Charge 4.c):

4. On 28 July 2020:

c) Did not follow Patient A's medical plan of care.

This charge is found proved.

The panel had regard to Patient A's clinical notes and an entry, dated 27 July 2020, about which Witness 4 gave evidence that the entry was made by him. This documented a plan of care in which Witness 4 noted:

'Second acute H/D [haemodialysis] session yesterday. Looks to be passing good amount of urine today… discussed taking each day bloods to assess need for further dialysis. As passing urine well may not need further dialysis…'

'Plan

- *EMB [early morning bloods] daily*
- *Assessed for possible dialysis tomorrow pending blood results*
- *…*
- *Monitor input/output – daily weights'.*

This entry was signed by advanced nurse practitioner Witness 4.

The panel noted that Patient A was not directly under the care of Mr Villegas that day, but had been allocated to Witness 3. Having initiated dialysis for Patient A, the panel concluded that Mr Villegas had done so contrary to the documented plan of care and consequently, charge 4c is found proved.

Fitness to practise

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

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

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

The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Submissions on misconduct

Mr Hugh-Jones referred to the case of *Doughty v GDC* [1988] AC164 and reminded the panel that impairment is a matter of judgment for the panel, and that there is no burden of proof. He submitted that, for a finding impairment, the conduct must be seriously below the reasonable standard.

Mr Hugh-Jones submitted that the facts found proved amounted to misconduct.

In relation to charge 1, Mr Hugh-Jones submitted that Mr Villegas improperly delegated tasks to a student nurse, (Witness 2) who was not trained to carry out the medical procedure. Mr Hugh-Jones further submitted that Mr Villegas's conduct in charge 3 undermines the nursing profession and its respect for patients. He also submitted that in relation to charge 4, Mr Villegas, was unqualified - a non-prescriber - and he presented a prescription that he knew to be invalid, and implemented unnecessary haemodialysis to Patient A. Mr Hugh-Jones reminded the panel that this Mr Villegas was aware of the policies governing delegation of tasks to student nurses and he prescribed the medical procedure knowing that the prescription was not valid.

Submissions on impairment

Mr Hugh-Jones 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 includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Mr Hugh-Jones reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Hugh-Jones submitted that by permitting Witness 2 to disconnect Patient B from haemodialysis, Mr Villegas exposed the patient to the risk of infection. Likewise, Witness 2's lack of experience in potentially dealing with an anaphylactic reaction by the patient and her lack of ability to deal with such an emergency meant that there was

further risk to the patient. Mr Hugh-Jones also pointed out that the risk of infection had been raised because Mr Villegas allowed Witness 2 to carry out the disconnection from haemodialysis in a non-aseptic manner.

In relation to charge 4, Mr Hugh-Jones submitted that the risks included over-dialysis. Dialysis lowers the creatinine levels preventing the patient's true creatinine levels being accessed.

Mr Hugh-Jones invited the panel to consider the seriousness of Mr Villegas's departure from good practice. He submitted that Mr Villegas exposed Witness 2 to excess and unnecessary pressure, in requiring her to act beyond her level of competence, which resulted in harm as a consequence of her conduct being scrutinised. He submitted that Mr Villegas's decision, in relation to charge 4, to override the nurse responsible for that patient (Witness 3) and prescribe a medical procedure to Patient B when he was not qualified to do so, was contrary to the plan of care and a departure from the fundamental tenets of the nursing profession.

Mr Hugh-Jones submitted that, by exposing Witness 2 to excess duties and Patient A to unnecessary treatment, Mr Villegas's conduct fell far below the standard expected of a registered nurse. He said that every registrant has a right to deny a charge, however, there is no evidence of remediation.

Mr Hugh-Jones submitted that Mr Villegas had, by his actions, demonstrated attitudinal issues in his cavalier exposure of Patient A and B to excess risk of harm and Witness 2 to duties beyond her level of competence.

Mr Hugh-Jones said that there are some testimonials to show where Mr Villegas had been working and he had produced some training certificates which have some relevance. However, he submitted that, overall, that there is insufficient evidence to demonstrate real or significant remediation.

Mr Hugh-Jones submitted that Mr Villegas's fitness to practise is currently impaired by reason of his misconduct on the grounds of public protection and also otherwise in the wider public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *Cohen v General Medical Council* [2008] EWHC 645 (Admin)

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: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) in making its decision.

The panel was of the view that Mr Villegas's conduct fell significantly short of the standards expected of a registered nurse, and that his actions amounted to breaches of the Code. These include:

> '***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*
> ***1.5** respect and uphold people's human rights*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *To achieve this, you must:*
> *3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*
>
> ***4 Act in the best interests of people at all times***
> *To achieve this, you must:*

4.2 make sure that you get properly informed consent and document it before carrying out any action

6 Always practise in line with the best available evidence

To achieve this, you must:

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

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

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

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

To achieve this, you must:

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.2 make a timely referral to another practitioner when any action, care or treatment is required
13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
13.4 take account of your own personal safety as well as the safety of people in your care

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations
To achieve this, you must:
18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs
18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
19.3 keep to and promote recommended practice in relation to controlling and preventing infection

20 Uphold the reputation of your profession at all times
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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to
20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
To achieve this, you must:
25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In reaching its decision, the panel made a determination on whether individually or collectively charges 1, 3 and 4 amount to misconduct.

The panel determined that the facts found proved in charge 1 amount to misconduct.

The panel determined that allowing an unqualified, unregistered and untrained student nurse to carry out the procedure to terminate haemodialysis, which has been described as an invasive procedure, exposed Patient B to significant risk of infection and aphylactic shock. The panel also determined that allowing a student nurse to carry out the tasks, subject of charge 1, was a breach of Trust policies. The panel further determined that Mr Villegas also put Witness 2 under significant risk of emotional harm. Furthermore, the procedure was not an aseptic and all witnesses told the panel the need for this procedure to be performed using an aseptic technique. However, Mr Villegas did not ensure that that was the case, instead permitted Witness 2 to undertake this procedure in clean rather than aseptic PPE.

The panel determined that the facts found proved in charge 3 amount to misconduct.

The panel noted that these comments were made in a closed Facebook chat group. However, it determined that Mr Villegas's comments would be deemed deplorable by other professionals and the public would be appalled to know that such comments were made by a registered nurse towards vulnerable patients. The panel took into account Mr Villegas's response to this charge but found that in no circumstances these comments can deemed acceptable.

The panel determined that the facts found proved in charge 4 amount to misconduct.

The panel heard evidence from several witnesses that haemodialysis is an invasive medical procedure, and Mr Villegas had prescribed it when he was not qualified to do so and had initiated the procedure. Mr Villegas's action put the patient at risk of over-dialysis and masking the creatinine level so that an accurate assessment could not be made. The panel noted the evidence of Witness 3, who was the primary nurse caring for Patient A. On seeing Patient A connected to dialysis, Witness 3 carried out observations and noticed a reduction in blood pressure and cardiac rate. By initiating haemodialysis, Mr Villegas did not discuss the case with Witness 3 and disregarded the plan of care set out in Patient A's medical notes. This was a serious departure of the standards required of an experienced Band 6 nurse.

The panel further noted Mr Villegas initiated a procedure that required a prescription when he knew that there was no prescription in place and ran that procedure for an hour and a quarter. Again, he did not seek to obtain any information from the primary nurse responsible for Patient A's care, namely Witness 3. The panel determined that this was a significant failing from an experienced Band 6 nurse.

The panel determined that Mr Villegas's actions in charges 4a and 4b, demonstrate that he did not follow the plan of care which is the subject of charge 4c. It determined that the plan of care was clear and well set out and Mr Villegas's behaviour was clearly at odds with it.

The panel was of the view that Mr Villegas's conduct in disregarding established policy and creating risks to patients, together with his categorisation of the chat group messages as 'funny', demonstrate a flippant and irresponsible attitude to his role.

The panel found that Mr Villegas's actions fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, Mr Villegas's fitness to practise is currently impaired. The panel recognised that the question of impairment in relation to Mr Villegas is to be decided today, although, in making its decision, the panel may have regard to his earlier conduct.

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

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

[…]'

The panel determined that limbs a, b and c of the above test are engaged in relation to Mr Villegas's conduct. By its findings, the panel concluded that Mr Villegas had put patients at unwarranted risk of harm and had brought the nursing profession into disrepute.

The panel concluded that vulnerable patients were put at significant risk of serious harm as a result of Mr Villegas's misconduct. Mr Villegas's misconduct breached numerous paragraphs of the Code as set out above and consequently undermined the fundamental tenets of the nursing profession across all three charges.

The panel had regard to the case of *Cohen* and considered whether the misconduct identified is capable of remediation, whether it has been remedied and whether there is a risk of repetition. In considering these issues, the panel had regard to the nature of the misconduct and considered whether Mr Villegas provided evidence of insight, remorse or strengthened practice. In addition, the panel took into account the responses to the

regulatory concerns, references from locum agencies and training certificates submitted by Mr Villegas.

The panel recognised Mr Villegas's right to deny the allegations subject of this hearing and to challenge facts and points of detail. The panel did not draw any inference from Mr Villegas's position, set out in his responses to the regulatory concerns and during the Trust investigation. The panel however, must consider insight and the likelihood of conduct being repeated in considering the public interest. In considering insight and any strengthening of practice, the panel took into account the training certificates and testimonials provided by Mr Villegas, noting that the testimonials do not refer to the allegations subject of this hearing.

The panel was satisfied that the misconduct in this case is capable of being remediated. The panel did not see any evidence of Mr Villegas's insight or to strengthening practice. In terms of the testimonials and training certificates provided by Mr Villegas, the testimonials are brief and dated July 2021. It is unknown whether Mr Villegas is currently employed or not as the panel has no evidence before it. The training certificates before the panel demonstrate mandatory training which had been completed up until September 2020; they do not support training relevant to any of the charges.

The panel therefore determined that it does not have evidence to show significant steps to strengthen his practice. The panel noted that it does not have a reflective piece provided by Mr Villegas which could have highlighted any insight into the facts found proved and his misconduct, or how he would do things differently to ensure that these events are not repeated.

The panel is of the view that the matters subject of this hearing are capable of remediation through strengthened practice and insight. However, there remains a risk of repetition based on the evidence available and the panel believes it likely that Mr Villegas will, in the future, act so as to put patients at unwarranted risk of harm, bring the nursing profession into disrepute and/or breach one or more fundamental tenets of the nursing profession.

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

It therefore found that Mr Villegas's fitness to practise is currently impaired on the grounds of public protection. In addition, it determined that public confidence in the nursing profession and in the NMC as the regulator would be undermined if a finding of impairment were not made.

Having regard to all the above, the panel was satisfied that Mr Villegas's fitness to practise is currently impaired on the grounds of both public protection and in the wider public interest.

Sanction

The panel considered this case carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Villegas off the register. The effect of this order is that the NMC register will show that Mr Villegas has been struck-off the register and not permitted to practise as a registered nurse.

In reaching this decision, the panel 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 Hugh-Jones informed the panel that, in the Notice of Hearing, dated 3 October 2022, the NMC advised Mr Villegas that it would seek the imposition of a striking-off order if it found Mr Villegas's fitness to practise currently impaired.

Mr Hugh-Jones submitted that the NMC is seeking a striking-off order because Mr Villegas's conduct fell so seriously below the standard expected of a registered nurse, that it is fundamentally incompatible with remaining on the NMC register. Mr Hugh-Jones said that at this stage the matter is left to the panel's experience and expertise, and the NMC's submission carries no special weight.

Mr Hugh-Jones submitted that the misconduct in this case is egregious. He said that in relation to charge 1 there was an exposure of Patient B, both consciously and wilfully, by Mr Villegas to infection and to the risk of a delayed reaction by the student nurse (Witness 2) should Patient B have suffered an anaphylactic reaction. There was an unnecessary and wilful tuition outside the known parameters for training, and a risk of student nurse (Witness 2) suffering a loss of confidence.

Mr Hugh-Jones submitted that in relation to charge 4, there were a series of conscious and wilful steps amounting to very serious departure from good practice. Mr Villegas was at the handover, he ignored the medical plan of care, he went over the head of Witness 3, created a prescription without any qualification to do so and initiated haemodialysis knowing there was no prescription for the procedure, which he ran for an hour and a quarter. This is a significant amount of time and it was only interrupted because Mr Villegas felt that he needed to seek a fluid removal assessment from Witness 4. Mr Hugh-Jones submitted that charge 1 and 4 relate to conscious breeches of good practice and there is evidence of attitudinal issues and a cavalier disregard of good practice.

Mr Hugh-Jones informed the panel that, Mr Villegas has never previously been referred to the NMC. Mr Hugh-Jones further reminded the panel that, when taken into account that there has been 20 years of good regulatory practice, the panel is now dealing with two incidents of misconduct or departures from good practice. He said that these incidents are isolated against a 20-year history which the panel can take into account when making a decision on sanction.

Decision and reasons on sanction

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

- Mr Villegas's conduct put vulnerable patients at risk of serious harm
- there were two serious clinical incidents within a period of five weeks.
- The panel saw evidence of attitudinal issues in relation to charge 3, around inappropriate Facebook messages
- Mr Villegas demonstrated a poor attitude in disregarding established policies and good practice in relation to charges 2 and 4
- Mr Villegas displayed a lack of candour when confronted with the matters around the allegation in charge 1. Mr Villegas denied to Witness 3 that he allowed the student nurse to carry out the procedure to disconnect Patient B from haemodialysis. Shortly afterwards, he made the same denial to Witness 1, but when confronted with the evidence, admitted allowing the student nurse (Witness 2) to carry out the procedure, but denied any knowledge of the Trust policy. Later, during the Trust investigation interview, he reversed his position, admitting knowledge of the policy but denying that he allowed the student nurse to carry the procedure. Again, when he wrote his responses to the regulatory concerns, he denied that the student nurse had been allowed to carry out the procedure
- By allowing her to do something that she was not permitted or trained to do, Mr Villegas compromised the student nurse (Witness 2) and put her immediate career at risk. Additionally, in allowing the student nurse (Witness 2) to carry out the disconnection of Patient A from haemodialysis, Mr Villegas coached the incorrect procedure because an aseptic technique was not used.
- The case is characterised by serious departures from standard practice and policies and significant breaches of the Code.

The panel also took into account the following mitigating features:

- The panel did not see evidence of past regulatory concerns
- The charges referred to three isolated incidents over a five week period, in the context of a 20-year career in the UK, during which no previous regulatory concerns have arisen.
- In terms of general work environment and context, the incidents occurred during the early stage of the pandemic when things were uncertain in hospital settings.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of its findings on facts and impairment, and the public protection issues identified, an order that does not restrict Mr Villegas's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where:

> *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'*

The panel considered that Mr Villegas's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of its findings on facts and impairment. 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 Mr Villegas's registration would be a sufficient and appropriate response. The panel is of the view that there might be practical or workable conditions that could be formulated, given the nature of the charges in this case.

The panel determined, however, that whilst there is no evidence of general or widespread incompetence on Mr Villegas's part, there is evidence of him demonstrating, generally a slipshod and irresponsible attitude towards policy and established working practices that were designed to secure patient safety and minimise risks.

The panel determined that the misconduct identified in this case could be addressed through retraining. The panel has no evidence of whether Mr Villegas is currently working or not, and there is no evidence to suggest that he would comply with any conditions the panel may impose given his lack of engagement with the regulatory process. Furthermore, the panel concluded that placing conditions on Mr Villegas's registration would not adequately address the seriousness of this case and would not protect the public or address the wider public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the incidents were,

in themselves, isolated given that they took place over a five week period in a 20 year career in the UK, but they formed a series which had the potential to put vulnerable patients at significant risk of harm. The panel also determined that there are some attitudinal issues in relation to patient safety and adhering to the established principles and policies of good practice. Mr Villegas was working as a senior nurse in a specialised area of hospital care and, in the face of multiple breaches of the Code, and no evidence of insight or strengthened practice, the panel was not satisfied that the facts found proved will not be repeated.

For these reasons, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in considering at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel also took account of the NMC guidance: 'How we determine seriousness' and the three broad categories of factors which may indicate the seriousness of a case as follows:

- *'Serious concerns which are more difficult to put right*
- *Serious concerns which could result in harm to patients if not put right*
- *Serious concerns based on the need to promote public confidence in nurses, midwives and nursing associates'*

Mr Villegas's behaviour engages factors which point to a greater level of seriousness under each of the above three headings relating to his:

- Breaching the professional duty of candour

- Being directly responsible for exposing patients to harm
- Failing to uphold people's dignity and treat them with respect
- Failing to be accountable for his decision to delegate a task
- Failing to recognise and work within the limits of competence
- Failing to advise, prescribe or administer medicines in line with training and guidance
- Failing to be aware of or reduce as far as possible, any potential for harm including controlling and preventing infection

Mr Villegas's conduct consisted of significant departures from the standards expected of a registered nurse, and is fundamentally incompatible with him remaining on the NMC register. The panel was of the view that the findings in this particular case demonstrate that Mr Villegas's actions were serious and to allow him to continue practising would undermine public confidence in the nursing profession and in the NMC as a regulatory body.

The panel determined that Mr Villegas's conduct raises fundamental questions about his professionalism. The regulatory concerns are multiple, wide ranging and occurred over a relatively short period of time, during a long career. Having regard to the guidance reproduced above, the misconduct is serious with real risk of harm to the patients involved and breached multiple areas of the Code.

The panel determined that Mr Villegas was directly responsible for exposing patients to harm. In addition, he failed to uphold the dignity of the people subject of his Facebook messages and he did not consider the physical and psychological needs of the patients he responded to. He also failed to account for the decisions to delegate tasks and duties to other people and failed to recognise the need to work with the limits of competence of himself and others.

Having regard to his clinical failings, the panel was of the view that Mr Villegas presented a material risk to the public should he continue practising at this time and, in addition, because of his failings, a more serious sanction is justified in this case in order

to declare and uphold proper standards and maintain public trust and confidence in nurses, midwives and nursing associates.

The panel noted that Mr Villegas's serious breaches of the fundamental tenets of the nursing profession evidenced by his conduct are fundamentally incompatible with him remaining on the NMC register.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

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.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Hugh-Jones. He submitted that an interim suspension order is necessary to cover the period until the striking-off order comes into effect having regard to the panel's findings. Mr Hugh-Jones submitted that if Mr Villegas appeals the decision of the panel, then he would be able to practice without restrictions until the appeal process is finished and this can take up to 18 months. He invited the panel to impose an order for a period of 18 months to cover the whole of the appeal period.

Decision and reasons on interim order

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

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

If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after Mr Villegas is sent the decision of this hearing in writing.

This decision will be confirmed to Mr Villegas in writing.

That concludes this determination.