Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 20 March 2023 - Wednesday 12 April 2023

Virtual Hearing

Name of Registrant:	Irene Ann Aird
NMC PIN	91Y0223S
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 8 January 1995
Relevant Location:	Norfolk
Type of case:	Misconduct and Lack of competence
Panel members:	Konrad Chrzanowski (Chair, Lay member) Laura Scott (Registrant member) David Anderson (Lay member)
Legal Assessor:	Nigel Pascoe KC
Hearings Coordinator:	Berivan Genc
Nursing and Midwifery Council:	Represented by Lucy Chapman, Case Presenter
Miss Aird:	Not present and not represented
Facts proved:	**Charge 1, 2, 3, 6, 7, 9, 12, 13, 14(a-d),16-26, 27(a-c), 28, 29, 31-35, 37-50, 52-55**
Facts not proved:	**Charge 4, 5, 10, 11, 27(d), 36, 51(a-c)**
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 Miss Aird was not in attendance and that the Notice of Hearing letter had been sent to Miss Aird's registered email address on 17 February 2023.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Miss Aird's registered address on 17 February 2023. It was signed for against the printed name of 'I. Aird'.

Ms Chapman, 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 allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Aird's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Miss Aird 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 Miss Aird

The panel next considered whether it should proceed in the absence of Miss Aird. It had regard to Rule 21 and heard the submissions of Ms Chapman who invited the panel to continue in the absence of Miss Aird. She submitted that Miss Aird had voluntarily absented herself.

Ms Chapman referred the panel to the letter of the Notice of Hearing sent from the NMC to Miss Aird, which was delivered to Miss Aird's address on 17 February 2023. Ms Chapman also referred the panel to the email and telephone notes of the communication between the case coordinator and Miss Aird dated 27 February 2023, which states that Miss Aird is content for hearing to proceed in her absence. Ms Chapman submitted there is no reason to suppose that adjourning would secure Miss Aird's attendance at some future date and also submitted that Miss Aird stated that she no longer wishes to practice as a nurse. Ms Chapman submitted that it would be fair in all circumstances to proceed in absence.

The panel has decided to proceed in the absence of Miss Aird. In reaching this decision, the panel has considered the submissions of Ms Chapman and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Aird;
- Miss Aird has engaged with the NMC and has responded to the letters and emails sent to her about this hearing;
- Miss Aird has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred between 2017 and 2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Aird in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her 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. Furthermore, the limited disadvantage is the consequence of Miss Aird's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Miss Aird. The panel will draw no adverse inference from Miss Aird's absence in its findings of fact.

Details of charge (as amended)

That you, whilst employed by Norfolk and Norwich University Hospitals NHS Foundation Trust as a Registered Nurse between 31 July 2017 to 4 April 2018:

1) On 19th October 2017, removed a catheter from an unnamed patient without consulting a senior colleague or doctor. **[PROVED]**

2) On 20th October 2017, failed to review and/or request an ECG for an unknown patient with a radial access compression band for 5 hours. **[PROVED]**

3) On 20th October 2017, failed to conduct the following for an unknown patient:
   a. Review; **[PROVED]**
   b. Observations; **[PROVED]**
   c. Complete admission paperwork. **[PROVED]**

4) On 8th November 2017, changed the rate of an IV infusion from a prescribed rate of 125ml per hour to 200ml per hour, without consulting a senior colleague or doctor. **[NOT PROVED]**

5) On 13th December 2017, failed to give a full handover to your colleagues. **[NOT PROVED]**

6) On 27th December 2017, failed to turn up for a shift at work. **[PROVED]**

7) On 30 December 2017, took a photo of a patient's rash on your mobile phone. **[PROVED]**

8) On 1st January 2018, removed an unknown patient's catheter without consulting a senior colleague or doctor. **[CHARGED REMOVED AS NO EVIDENCE OFFERED]**

9) On 6th January 2018, failed to get an unknown patient ready for admission when allocated. **[PROVED]**

10) On 8th January 2018, failed to prepare an unknown patient with a cannula prior to their admission to the cath labs. **[NOT PROVED]**

11) Failed to complete your mandatory training in a timely manner. **[NOT PROVED]**

12) On an unknown date, discharged a patient without a discharge letter or documentation. **[PROVED]**

13) On or around 11th January 2018, failed to complete admission paperwork and/or review an unknown patient. **[PROVED]**

14) On or around 11th January 2018, failed to complete the following documentation for an unknown patient:

a) MUST; **[PROVED]**
b) Waterlow; **[PROVED]**
c) Care plans; **[PROVED]**
d) Nursing assessment. **[PROVED]**

15) On or around 11th January 2018, removed an unnamed patient's catheter without consulting a senior colleague or doctor. **[CHARGED REMOVED AS NO EVIDENCE OFFERED]**

16) On or around 11th January 2018, failed to carry out a bladder scan for an unknown patient, following the removal of the patient's catheter. **[PROVED]**

17) On 18 January 2018, told Colleague A that "don't worry, it's our secret" or words to that effect when you informed her that she had left a needle in the cannula of an unnamed patient. **[PROVED]**

18) On 18th January 2018, acted without integrity by failing to complete a datix or make a report to management having disclosed to Colleague A that she had left a needle in the canula of an unnamed patient. **[PROVED]**

That you, whilst employed by Spire Healthcare as a Registered Nurse between 18 June 2018 to April 2019:

19) On 10 July 2018, refused to assist colleague X with a patient/and or drug check when asked. **[PROVED]**

20) On unknown dates between 18 June 2018 to October 2018, took long breaks from the ward without informing your colleagues **[PROVED]**

21) On 24th August 2018, attempted to give a patient Tramadol without checking the patient's drug chart first. **[PROVED]**

22) On 27th September 2018, gave a patient an incorrect dose of 10mg Oxycontin instead of 5mg. **[PROVED]**

23) On 24th August 2018, did not check the expiration date of paracetamol to be administered intravenously to an unnamed patient before attempting to administer it. **[PROVED]**

24) On 3rd October 2018, wandered off during handover without explanation. **[PROVED]**

25) On an unknown date in October 2018, removed PCA pump from a patient without consultation with a senior colleague or doctor. **[PROVED]**

26) On an unknown date, did not attend to a cardiac arrest scenario when the emergency bell was called. **[PROVED]**

27) Between 3rd October 2018 to 22nd October 2018, you did not complete the following documents accurately:

a) daily care pathways TG/2; **[PROVED]**
b) HELP charts TG/2; **[PROVED]**
c)) fluid charts.TG/2; **[PROVED]**
d) NEWS chart TG/2. **[PROVED]**

28) On an unknown date, documented a 'ready for discharge time' on the recovery pathway before the patient was admitted. **[PROVED]**

29) On 6th October 2018, did not check a patient's drug chart and put eye drops into the wrong eye of an unnamed patient. **[PROVED]**

30) On 6th October 2018, put eye drops into the wrong eye of an unnamed patient. **[CHARGED REMOVED AS NO EVIDENCE OFFERED]**

31) On the 22nd October 2018, you failed to administer Lansoprazole to an unknown patient. **[PROVED]**

32) On the 25th October 2018, did not communicate to your colleagues when you did not administer drugs to patients on your drug round. **[PROVED]**

33) On an unknown date, did not know how to treat a patient having a vaso vagal attack. **[PROVED]**

34) On an unknown date, tried to mobilise a post hip operation patient on your own without a colleague. **[PROVED]**

35) On an unknown date, failed to give an unnamed patient the full dose of Intravenous Cyclizine. **[PROVED]**

36) Failed to complete drug rounds in a timely manner throughout your period of supervision. **[NOT PROVED]**

37) Between 9th October 2018 and 22nd October 2018, failed to complete your mandatory training as requested. **[PROVED]**

That you, whilst employed by Dussindale Care Home as a Registered Nurse on 20 to 21 October 2018:

38) Dispensed and/or administered 10 extra tablets of paracetamol for an unnamed patient. **[PROVED]**

39) Did not administer a dose of Levetiracetam 1g tablet to an unnamed patient on the following dates:
a) 20 October 2018, PM; **[PROVED]**
b) 21 October 2018, AM; **[PROVED]**
c) 21 October 2018, PM; **[PROVED]**

40) Signed the MAR chart of an unnamed patient to record paracetamol had been administered when you did not administer to said patient. **[PROVED]**

41) On 21 October 2018, signed the MAR chart of an unnamed patient to record Pregablin had been administered when you did not administer to said patient. **[PROVED]**

42) On 21 October 2018, signed the MAR chart of an unnamed patient to record Sodium Valporate 200mg was administered but you did not administer to said patient. **[PROVED]**

43) On 21st October 2018, did not sign an unnamed patient's MAR chart to record that Metformin and Quetiapine was administered to said patient. **[PROVED]**

44) On 20 October 2018, signed an unnamed patient's MAR chart to record Apixaban 2.5mg was administered but you did not administer to said patient. **[PROVED]**

45) On 20 October 2018 and/or 21st October 2018, signed an unnamed patient's MAR chart to record that Laxido was administered but you did not administer to said patient. **[PROVED]**

46) On 21 October 2018, signed an unnamed patient's MAR chart that 3 tablets of codeine 30mg was administered but you did not administer to said patient. **[PROVED]**

47) On 20 October 2018, did not sign the MAR chart following the administration of Levetiracetam 1g for an unnamed patient. **[PROVED]**

48) Failed to complete the PRN charts for all patients on both shifts despite a request from colleague X. **[PROVED]**

That you, whilst employed by Two Acres Care Home as a Registered Nurse between 6 February 2020 to 18 February 2020:

49) On 15th February 2020, failed to sign an unknown patient's MAR chart, following an administration of calcit -D to said patient. **[PROVED]**

50) On 17th February 2020, signed to record on an unnamed patient's MAR chart that Rivaroxaban was administered before you had administered such to that patient. **[PROVED]**

51) On 17th February 2020, signed to record that the following medications were administered to an unnamed patient but you did not administer to said patient:
    a) Laxido orange oral powder; **[NOT PROVED]**
    b) Folic acid 5mg; **[NOT PROVED]**
    c) Oxybutynin 5mg. **[NOT PROVED]**

52) On 18th February 2020, signed to record on an unnamed patient's MAR chart that medication had been administered before you had administered it. **[PROVED]**

53) On 18th February 2020, stated to colleague B that 'everywhere you had worked, you signed first' or words to that effect. **[PROVED]**

54) On 18th February 2020, you told colleague C "Never had to wait for the patient to take the tablet before signing the administration chart. Not in any previous workplace" or words to that effect. **[PROVED]**

55) Your actions at charges 53) and/or 54) was dishonest as you sought to provide a misleading account of your work experience to justify your actions. **[PROVED]**

AND, in the light of the above, your fitness to practise at charges 1-5, 7-16, 19 – 29, 31 – 37 is impaired by reason of your lack of competence and/or misconduct and at charges 6, 17-18, 38 – 55 by reason of your misconduct.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Chapman, on behalf of the NMC, to delete charges 8 and 15 as there is no evidence to support either of those charges. She submitted that charge 8 was explored by Witness 1 who clarified that he only recalled two incidents regarding reporting a catheter. Witness 10 stated in her evidence that she had removed the catheter.

In relation to the incident at charge 8, Ms Chapman submitted that Witness 1 stated that this incident occurred during early October and not on 1 January 2018. Ms Chapman also submitted that there is nothing to support this charge. Ms Chapman further submitted that Witness 10 clarified as per her statement and exhibit that she was the one who removed the catheter and not Miss Aird, but charge 15 states that it was Miss Aird. Therefore, Ms Chapman submitted that it would be sensible to remove charge 15 due to insufficient evidence and it being incorrect.

Ms Chapman referred the panel to the case of *Ogundele v* NMC [2013] EWHC 2748 (Admin) [15] and submitted that it appears that there is force in the submission of the NMC that in a case where it is asserted there is a long-standing pattern of lack of confidence, and not simply a few isolated episodes, there inevitably will be a volume of incidents revealing the pattern.

Ms Chapman submitted that charges 13 and 14(a)-(d) should also be amended as Witness 10 clarified in her evidence that these events took place on 10 January 2018. Therefore, Ms Chapman submitted that it would be reasonable to amend these charges to read on or around 11 January 2018 as the evidence still remains the same and that this is merely for purposes of clarity.

Ms Chapman submitted that charge 51(c) should be amended as there is a spelling error of the medication namely, “oxydutynin” when it should read as “oxybutynin”.

She submitted that upon reflection, this was how the witness had pronounced it and having researched the medication, it appeared that there was no medication called “oxydutynin”. She submitted that no prejudice would be caused to Miss Aird as this is for clarification purposes.

Ms Chapman also made an application to amend the wording of charges 39(a)-(c), 47, 43, 53, 54 and to remove charge 30.

The proposed amendment was in order to correct spelling errors and dates for the purposes of accuracy and no prejudice was caused to Miss Aird by making those amendments. It was submitted by Ms Chapman that the proposed amendment would provide clarity and accuracy without causing prejudice to Miss Aird in relation to the names of the medications and the date Miss Aird commenced her employment. Ms Chapman submitted that charge 30 should be deleted as this is a duplicate and causes unfairness to Miss Aird and that the panel would be assisted by the NMC guidance on facts, evidence and the charges.

“That you, a registered nurse:

~~8. On 1st January 2018, removed an unknown patient’s catheter without consulting a senior colleague or doctor.~~

13. **On or around** 11 January 2018, failed to complete admission paperwork and/or review an unknown patient.

14. **On or around** 11 January 2018, failed to complete the following documentation for an unknown patient:
    a) MUST
    b) Waterlow
    c) Care plans
    d) Nursing assessment

~~15. On or around 11th January 2018, removed an unnamed patient’s catheter without consulting a senior colleague or doctor.~~

~~30. On 6th October 2018, put eye drops into the wrong eye of an unnamed patient.~~

39. Did not administer a dose of ~~Levitaraceum~~ **Levetiracetam** 1g tablet to an unnamed patient on the following dates:
a) 20 October 2018, PM
b) 21 October 2018, AM
c) 21 October 2018, PM

43. On 21st October 2018, did not sign an unnamed patient's MAR chart to record that Metformin and ~~Quietapin~~ **Quetiapine** was administered to said patient.

47. On 20 October 2018, did not sign the MAR chart following the administration of ~~Levitaraceum~~ **Levetiracetam** 1g for an unnamed patient.

51. On 17th February 2020, signed to record that the following medications were administered to an unnamed patient but you did not administer to said patient:

c)~~Oxydutynin~~ **oxybutynin** 5mg

53. On 18th ~~January~~ **February** 2020, stated to colleague B that 'everywhere you had worked, you signed first' or words to that effect.

54. On 18th ~~January~~ **February** 2020, you told colleague C "Never had to wait for the patient to take the tablet before signing the administration chart. Not in any previous workplace" or words to that effect.

AND, in the light of the above, your fitness to practise at charges 1-5, 7-16, 19 - 29, 31-37 is impaired by reason of your lack of competence and/or misconduct and at charges 6, 17-18, 38-55 by reason of your misconduct.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted that charge 8 should be removed as there is no evidence to support this charge and it had also accepted Witness 1's evidence that charge 8 refers to the earlier incident of 19 October 2018.

In relation to charges 13 and 14a-d, the panel accepted the witness's evidence who confirmed that this occurred on 10 January 2018 and the panel also accepted legal advice that no prejudice was caused to Miss Aird. Therefore, it decided that these charges can be amended.

In relation to charge 15, the panel accepted the Witness's evidence including documentary evidence and that this was done by the Witness and not Miss Aird. Therefore, the panel determined that this charge can be removed.

The panel determined that it was content for the wording of the medication in charge 51c to be amended as this is for purposes of accuracy and no prejudice would be caused to Miss Aird.

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Aird and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

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

At the outset of the hearing, Ms Chapman made a request that this case be held partly in private on the basis that proper exploration of Miss Aird's case involves references to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined to rule on whether or not to go into private session in connection with any references made to [PRIVATE] as and when such issues are raised.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Chapman under Rule 31 to allow the hearsay testimony of Witness 3, Witness 11 and Witness 12 into evidence. Ms Chapman submitted that the evidence is highly relevant and though not provided during the course of the NMC's investigation, was produced for the purpose of the internal investigations.

Ms Chapman submitted that Witness 3 was employed as a Nurse Ward Manager and as her line manager, had put Miss Aird on a Performance Improvement Programme ('PIP') in response to the concerns raised with her.

The panel was of the view that, although Miss Aird had chosen not to attend this hearing and had no objections to these witnesses' hearsay testimonials, Witness 3's evidence is important to consider as she was Miss Aird's line manager at that time and it would assist the panel if Witness 3 could attend the hearing to provide further detail where necessary.

The panel determined that it was a basic principle of fairness that Miss Aird is given the opportunity to factor this into any defence to present to the panel.

In these circumstances, the panel refused the application for Witness 3 to be heard as hearsay.

Ms Chapman submitted that Witness 11 was employed as a Quality and Compliance Inspector who monitors the Home to check whether regulations have been complied and concerns were escalated to her as part of the investigation. Miss Chapman submitted that Witness 11's statement provides explanatory and background evidence and that it is proportionate to submit this to the panel considering there is no challenge to Witness 11's statement.

She submitted that Witness 12 was employed as a Nurse Branch Manager and concerns were escalated to her as part of the investigation by the individual who dealt with the issue directly and the matron who managed people at the time.

Miss Chapman submitted that in the preparation of this hearing, the NMC had indicated to Miss Aird both via email and telephone records on 27 February 2023 that it was the NMC's intention for these witnesses to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 3, Witness 11 and Witness 12, Miss Aird had no objection to these witnesses, accepted the allegations and decided not to attend this hearing. On this basis, Ms Chapman advanced the argument that there was no lack of fairness to Miss Aird in allowing Witness 3, Witness 11 and Witness 12's written statement into evidence.

The panel was of the view that, although Miss Aird had chosen not to attend this hearing and had no objections to these witnesses' hearsay testimonials, Witness 12's evidence is important to consider as Witness 12 was the Nurse Branch Manager. It would assist the panel if Witness 12 could attend the hearing to provide further detail where possible.

The panel determined that it was a basic principle of fairness that Miss Aird is given the opportunity to factor this into any defence to present to the panel.

In these circumstances, the panel refused the application for Witness 12 to be heard as hearsay.

The panel gave the application in regard to Witness 11 serious consideration. The panel noted that Witness 11's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement is true to the best of my information, knowledge and belief' and signed by her but allowed the hearsay application of Witness 11.

The panel considered that as Miss Aird had been provided with a copy of Witness 11's statement and, as the panel had already determined that Miss Aird had chosen to absent herself voluntarily from these proceedings, she would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 11 and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Witness 11 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The charges arose whilst Miss Aird was employed as a registered nurse by Spire Healthcare ('the Organisation'). Miss Aird was referred to the NMC on 24 May 2019, by (the Organisation).

Between 31 July 2017 and 4 April 2018, she was employed by Norfolk and Norwich University Hospitals NHS Foundation Trust ('the Trust'). She was working in the Cardiology department.

Concerns were raised about her practise regarding:

- poor quality handovers;
- inability to handle stressful situations;
- poor communication; and
- failure to follow the correct processes when discharging patients.

Due to the concerns, Miss Aird was moved to the elective unit in October 2017. This was a less acute area and would enable her to get the support she required to develop her nursing knowledge and skills. However, the concerns remained.

Some of the concerns raised on the elective unit were:

- failure to conduct review, observations, and admission paperwork;
- Failed to review and/or request an ECG for an unknown patient with a radial access compression band for 5 hours;
- not completing full handovers;
- removal of a catheter from a patient without consulting a senior colleague or doctor;

On 8 November 2017, changed the rate of an IV infusion from a prescribed rate of 125ml per hour to 200ml per hour, without consulting a senior colleague or doctor.

On December 2017, Miss Aird's probation at the Trust was extended for three months. During these three months, further concerns were raised regarding her practise. These were:

- took a photo of a patient's rash on her personal mobile phone;
- failed to give a full handover to her colleagues;
- failed to turn up for a shift at work;

On February 2018 the concerns were as follows:

- removed an unknown patient's catheter without consulting a senior colleague or doctor;
- failed to get an unknown patient ready for admission when allocated;
- failed to prepare an unknown patient with a cannula prior to their admission to the cath labs.
- Failed to complete mandatory training in a timely manner.
- On an unknown date, discharged a patient without a discharge letter or documentation.
- failed to complete admission paperwork and/or review an unknown patient.
- failed to complete the following documentation for an unknown patient:

    - MUST
    - Waterlow
    - Care plans
    - Nursing assessment

- removed a further unnamed patient's catheter without consulting a senior colleague or doctor.
- failed to carry out a bladder scan for an unknown patient, following the removal of the patient's catheter.
- told Colleague A that "don't worry, it's our secret" or words to that effect when you informed her that she had left a needle in the cannula of an unnamed patient.
- acted without integrity by failing to complete a datix or make a report to management having disclosed to Colleague A that she had left a needle in the cannula of an unnamed patient.

On 4 April 2018, it was decided that Miss Aird had failed her probation period at the Trust and her employment was terminated.

On 20 May 2018, she joined a nursing agency, Nurseplus ('the Agency'). Whilst maintaining her employment with the Agency, she also commenced employment with Spire on 18 June 2018.

Following her induction period with Spire, she worked as a supernumerary for three to four weeks. During these weeks, a number of concerns were identified. These were:

- failure to complete accurately a NEWS score for patients;
- lacked knowledge around medication administration;
- had poor documentation skills; and
- was unable to adequately carry out and "A to E" assessment of a deteriorating patient

A PIP was commenced on 17 September 2018 to help support Miss Aird and develop her knowledge and skills. This was due to be completed on 29 November 2018.

Whilst she was completing her PIP, she did make progress, however, there were still a number of concerns with her practise. These were:

- placing pre-operative eye drops into the wrong eye of a patient
- would titrate cyclizine for post-operative patients, which was against policy
- failing to attend a CPR training scenario which was mandatory for everyone to attend
- failing to complete appropriate documentation for her patients.

On 5th October 2018, she was made supernumerary again due to the concerns identified. Whilst supernumerary, she completed three supervised drug rounds but drug errors persisted. Poor communication also persisted.

She was suspended from Spire in October 2018 and her employment was terminated around April 2019.

Whilst suspended from Spire, the Agency placed the registrant at Dussindale Care Home ('the Home'). She completed two shifts for the Home in October 2018. During these two shifts:

- three tablets of codeine were not signed for
- 10 paracetamol tablets had gone missing
- failed to give pregabalin and sodium valproate to a resident
- failed to sign a resident's MAR
- failed to give leviteracetam to a resident

On 6 February 2020, she commenced employment at Two Acres Care Home ('Two Acres').

On 18 February 2020, as part of her induction, she was supervised doing a medication round. During this round, she checked the MAR of the patient, dispensed the medication and signed for it before administering it to a patient. This was incorrect practice. She was informed of this but she became defensive and adamant that she was right and that Two Acres policy was wrong and unsafe.

It was also identified that during other medication administration rounds she failed to sign for medications or that her signature was crossed out and a "G" was in its place. This indicated that she had pre-signed for the medication and then a patient had refused it, so she had to change the MAR. She also failed to administer medication to patients covertly, even when this was part of their care plan.

Miss Aird is alleged to have been dishonest as she provided a misleading account of her work experience to justify her actions.

Two Acres decided that they were unable to continue with her employment and it was terminated.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Chapman on behalf of the NMC and by Miss Aird's response through her documentary evidence.

The panel has drawn no adverse inference from the non-attendance of Miss Aird.

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

The panel heard live evidence from the following witnesses called on behalf of the NMC and also considered a hearsay evidence from one witness as follows:

- Witness 1: Band 6 Cardiology Nursing Manager
- Witness 2: Breast Specialist Nurse
- Witness 3: Ward Matron
- Witness 4: Band 6 Cardiology Nurse
- Witness 5: Ward Sister
- Witness 6: Theatre Matron
- Witness 7: Care Home Manager
- Witness 8: Training Coordinator
- Witness 9: Registered Manager
- Witness 10: Deputy Sister
- Witness 11 (hearsay evidence): Regional Director
- Witness 12: Branch Manager

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC and the documentary evidence from Miss Aird.

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

Charge 1

> That you, whilst employed by Norfolk and Norwich University Hospitals NHS Foundation Trust as a Registered Nurse between 31 July 2017 to 4 April 2018:
>
> 1) On 19th October 2017, removed a catheter from an unnamed patient without consulting a senior colleague or doctor.

In reaching this decision, the panel took into account Witness 4's evidence as she was the nurse who noticed the patient in the wheelchair leaving the ward and "*he appeared to be in considerable pain*". Witness 4 was told by the patient that he had his catheter removed in the morning and when Witness 4 asked Miss Aird why she had removed his catheter, her response was that she did not think patients could be sent home with catheters and that "*only she felt he shouldn't be discharged with a catheter."*

The panel considered that when asked, Miss Aird did not discuss removing the catheter with her colleagues and upon further question, she repeated that she thought the patient could not go home with the catheter and removed it. Witness 4 both in her written and oral evidence confirmed the above and submitted that she reported this incident to her line manager via email dated 24 October 2017 and produced a file note dated 30 October 2017 in relation to Cath labs.

The panel also considered both documentary and oral evidence from Witness 1 who confirmed he was made aware of the concerns raised as stated above via the email dated 24 October 2017 regarding the removal of the catheter and the file note.

The panel determined that on the basis of the evidence before it, on the balance of probabilities, it found this charge proved.

This charge is found proved.

Charge 2

> On 20th October 2017, failed to review and/or request an ECG for an unknown patient with a radial access compression band for 5 hours.

The panel took into account Witness 1's statement and meeting notes where he stated that he had a discussion with Miss Aird regarding the issue of a radial access compression band being left on for 5 hours post procedure with no review and no ECG "*despite this being requested three times by the co-ordinator*". In response to this, Witness 1 in his evidence submitted that Miss Aird said that she *"only had one pair of hands."* Witness 1 also stated that Miss Aird *"became visibly frustrated and a bit angry".*

The panel also noted in Witness 1's meeting notes that further issues were discussed with multiple patients arriving to the laboratory without appropriate checklists completed.

The panel considered the email dated 20 October 2017 regarding the issue on 20 October 2017 which stated that Miss Aird had forgotten that the patient was hers with no observations or admission paperwork completed despite the patient being over 4 hours post procedure. The patient had reported that radial access site had not been looked at since they left the laboratory.

The panel further considered the file note dated between 27 and 28 February 2017, which states that the Deputy Sister found a patient who arrived in the radial lounge at 10:00 and still had his radial access clamp on 5 hours later. It also states that:

> "*this is a mirror incident demonstrating no learning has taken place*."

"*when challenged on this, Irene did not know much about the patient or where he was at in the discharge process".*

The file note further states that the Deputy Sister had asked Miss Aird to do an ECG three times and this was not carried out. The panel noted that the date of the email reference on the file note matches the date of this charge.

The panel determined that considering Miss Aird had a similar incident previously (as per the file note dated 27-28 February 2017, suggests there could have been an incident prior to this date. However, it determined that it is highly likely that the reference to the previous issue is not the one referred to in this charge.

The panel also considered Witness 1's statement where he stated that Miss Aird had a second review meeting with a Clinical Facilitator where she reported being stressed, which led to her making more mistakes.

Therefore, the panel was of the view that on the balance of probabilities, this issue could have been repeated later on and on the basis of the evidence mentioned above, the panel decided that there is sufficient evidence to find this charge proved.

This charge is found proved.

Charge 3a) and 3b)

On 20th October 2017, failed to conduct the following for an unknown patient:

a. review
b. observations

The panel considered the email dated 24 October 2017 regarding the incident that occurred on 20 October 2017 which stated that Miss Aird had forgotten that the patient was hers with no observations or admission paperwork completed despite

the patient being over four hours post procedure. The patient had reported that radial access site had not been looked at since they left the laboratory.

The panel was of the view that the content of the information in the email above, refers to the same patient as charge 2 and the information in the meeting notes also refers to the same patient who had no radial access compression band with no review and no ECG. On the balance of probabilities, the panel found both charges 3a and 3b proved.

Charges 3a and 3b are found proved.

Charge 3c

On 20th October 2017, failed to conduct the following for an unknown patient:

c. complete admission paperwork.

The panel considered the reference to the email sent on 24 October 2017, which outlines the incident occurred on 20 October 2017. Similarly, Witness 1 also provided evidence that no admission paperwork was completed for that patient. Therefore, on the balance of probabilities, the panel found this charge proved.

This charge is found proved.

Charge 4

On 8th November 2017, changed the rate of an IV infusion from a prescribed rate of 125ml per hour to 200ml per hour, without consulting a senior colleague or doctor.

In reaching its decision, the panel considered Witness 1's evidence where in his statement he stated that one of the staff nurses had highlighted this concern by email on 8 November 2017. The patient was on an intravenous infusion with the prescribed rate to be 125ml per hour, but it was going at 200ml per hour. Miss Aird is reported to have said she "*sped it up*" because the patient was going for a chest x-ray.

The panel noted that the email sent from the staff nurse was not available before the panel. The panel determined that there is no other evidence to support this charge other than the statement provided by Witness 1 in relation to this incident, which is hearsay evidence and as such, the panel placed less weight upon it than if it had been first hand evidence. The panel considered the reference to an email dated 6 December 2017, which mentions concerns expressed from a senior staff member, but determined that it does not specifically mention the matter referred to in this charge.

On the balance of probabilities, the panel found this charge not proved on the basis of insufficient evidence.

This charge is NOT proved.

Charge 5

> "On 13th December 2017, failed to give a full handover to your colleagues."

The panel considered the email dated 13 December 2017 sent to Witness 1 in which the sender states:

> *"When in the radial lounge last week, the patient was brought down following the procedure by S/N Irene and I did not receive a full handover for the patient."*

The panel also acknowledged the second probationary period review meeting dated on 19 December 2017, which stated that in relation to handovers, some of your handovers for post procedure patients have been at a poor standard.

The panel noted that the charge is dated as 13 December 2017 and although the email was sent to Witness 1 on that date, the reference to "*last week*" suggests that the incident took place prior to the incident on 13 December 2017.

The panel held the view that this probably happened, but the charge and/or the date was worded incorrectly.

Therefore, on the balance of probabilities the panel determined that this incident did happen but it happened before 13 December 2017. The panel found this charge not proved.

This charge is found NOT proved.

Charge 6)

On 27th December 2017, failed to turn up for a shift at work.

In reaching its decision, the panel considered the evidence from Witness 1, which stated that he had discussed with Miss Aird in relation to her absence on 27 December 2017 and she had apologised for missing her shift and the impact this could have caused on patient safety.

The panel also took into account the meeting on 3 January 2018 where this matter was raised during that meeting. Therefore, the panel decided that there was a contemporaneous record of the meeting and found this charge proved.

This charge is found proved.

Charge 7)

On 30 December 2017, took a photo of a patient's rash on your mobile phone.

In reaching its decision, it took into account Witness 1's evidence where he stated that he received an email on 2 January 2018 in relation to this incident where Miss Aird had taken photographs of a patient's rash on her mobile phone. This email was produced as documentary evidence. The panel accepted that whilst there was no information that could identify the patient, there was a breach of private information

that someone has not consented to being shared on a device. The panel acknowledged that Miss Aird did not obtain GDPR training at the Trust.

The panel considered the meeting notes dated 3 January 2018, which record that during a formal discussion with Witness 1, *"Irene stated that she did this to show the patient the rash"*.

The panel also considered the meeting notes dated 10 January 2018 which stated:

> '*discussed with Irene issues highlighted since second review meeting, including not turning up for a shift, taking a picture of a patient's rash on her phone, using mobile phone at Nurses station on Coronary Care when on shift and issues with Irene not having properly prepared patients for procedures.'*

The panel found that on the balance of probabilities, there was sufficient evidence to find this charge proved.

This charge is found proved.

Charge 9

> On 6th January 2018, failed to get an unknown patient ready for admission when allocated.

The panel took into account the email sent to Witness 1 from the Deputy Sister on 8 January 2018, which referred to the previous Saturday (6 January 2018). This email expressed concerns about the admission procedure, such as the patient who was not in a gown, bed was not made and the bed area was untidy. Miss Aird also did not complete the required checklist and the patient had no cannula.

The panel also considered Witness 1's statement in which he stated that he received an email regarding Miss Aird failing to prepare a patient for a '*pinky*'. She had not done the required checklists and the patient did not have a cannula. This statement is also corroborated by Witness 1's file note prepared at the time.

The panel also noted the reference to "*the importance of pre-procedure preparation*", in the minutes of the meeting between Witness 1 and Miss Aird on 10 January 2018.

The panel determined that on the balance of probabilities, there is sufficient evidence to find this charge proved on the basis of the evidence above.

This charge is found proved.

Charge 10

> On 8th January 2018, failed to prepare an unknown patient with a cannula prior to their admission to the Cath labs.

The panel noted on the basis of the evidence before it, this incident happened on 6 January 2018 and not 8 January 2018. Whilst the panel is satisfied that this did happen, it determined that this is likely to have happened on 6 January 2018. The panel considered the email dated 8 January 2018, which states:

> *'…last Saturday I informed Irene first thing we would be doing a pinky from the ward who she was looking after.'*

The panel determined based on the content of this email, it is clear that the communication related to cannula incident, which would have been on 6 January 2018.

Therefore, found not proven due to the wrong date of the charge.

This charge is found NOT proved.

Charge 11

> Failed to complete your mandatory training in a timely manner.

The panel acknowledged Miss Aird's claim at the time that she did complete the training as much of it was covered during her induction, her attendance was subsequently confirmed by the mandatory training team. The panel also considered the email dated 5 January 2018 from the mandatory training team, which provided a screenshot of a list of the training modules. The panel noted that a column has been redacted and this document does not confirm what training was or was not completed by Miss Aird.

The panel considered the file note dated between 27 and 28 February 2018, which referred to discussions regarding Miss Aird's mandatory training and corporate induction. It states that Miss Aird failed to attend her initial corporate induction and despite being rebooked, there is no evidence of her attendance as she did not sign in. The panel acknowledged Miss Aird's response in that she disputed this by saying that she did complete the training as much of it was covered during her induction and her attendance was confirmed by a mandatory training team.

The panel finds this charge not proven due to lack of specific requirements and dated training records.

This charge is found NOT proved.

Charge 12

> On an unknown date, discharged a patient without a discharge letter or documentation.

The panel viewed the Datix report dated 11 December 2017, which stated that normal practice is to discharge patients with a letter and two weeks supply of medications. On investigation, no discharge documentation was completed for the patient and no discharge letter was sent with the patient. The file note dated 11 December 2017 also stated that Miss Aird could offer no good explanation for her course of action during the meeting. The panel also noted that she did not deny the allegation.

The panel also considered the record of the second probationary period review meeting dated 19 December 2017 at which this incident was discussed.

The panel was satisfied that while there is no evidence for a specific date of discharge, it is likely to be around that time.

The panel noted Witness 1's oral evidence in which he outlined the details of the discharge procedure for patients. He also stated that there was no documentation as to why the discharge was not completed.

On the balance of probabilities, the panel found this charge proved.

This charge is found proved.

Charge 13

> On or around 11 January 2018, failed to complete admission paperwork and/or review an unknown patient.

The panel considered the evidence from Witness 1 and Witness 10 in relation to the concern raised in this charge. An email was sent from Witness 10 to Witness 1 on 11 January 2018, which highlights concerns regarding Miss Aird's failure to complete the admission paperwork for a patient for the whole shift with only basic observations completed and failure to state whether the patient had passed urine and had not carried out a bladder scan. This was confirmed by both Witnesses in their written and oral evidence.

Witness 1 in his evidence provided further detail in relation to the email on 11 January 2018 regarding those issues. He stated that this patient came in from Accident and Emergency (A&E) and needed full nursing documentation along with basic nursing assessments such as, MUST, Waterlow, care plans and nursing assessments should have been completed as soon as possible. In relation to the issue of review, Witness 1 stated:

'*this is a fundamental question for a post catheter patient as if they are not urinating they could be going into retention which is a medical emergency.'*

With regard to all the above, the panel determined that the evidence provided by both Witnesses corroborates with the concern raised in this charge. Therefore, on the balance of probabilities, the panel find this charge proved.

This charge is found proved.

Charge 14a)

On or around 11 January 2018, failed to complete the following documentation for an unknown patient:

a) MUST"

The panel considered the email from Witness 10 dated 11 January 2018 as stated above, which highlights the concerns of no admission paperwork had been completed and this was reiterated by Witness 1 in his statement including his oral evidence. The panel also considered Witness 10's oral evidence where she stated that the MUST score is expected to be completed as part of the admission process and it is a specific tool that must be used, but this was not carried out.

Based on this evidence before the panel, on the balance of probabilities, it found this charge proved.

This charge is found proved.

Charge 14b)

On or around 11 January 2018, failed to complete the following documentation for an unknown patient:

b) Waterlow

The panel considered the email from Witness 10 dated 11 January 2018 as stated above, which highlights the concerns of no waterlow had been completed and this was reiterated by Witness 1 in his statement including his oral evidence. The panel also considered Witness 10's oral evidence where she stated that the waterlow is expected to be completed as part of the admission process and it is a specific tool that must be used, but this was not carried out.

Based on this evidence before the panel, on the balance of probabilities, it found this charge proved.

This charge is found proved.

Charge 14c)

On or around 11 January 2018, failed to complete the following documentation for an unknown patient:

c) Care plans

As stated above for both charges 14a and 14b, the panel considered the evidence from Witness 10 in relation to her email dated 11 January 2018 and her statement, which highlights the concerns of no waterlow had been completed. This was reiterated by Witness 1 in his statement and had confirmed this in his oral evidence. The panel also considered Witness 10's oral evidence where she stated that a care plan is also expected to be completed as part of the admission process and must be used as part of the procedure, but this was not carried out by Miss Aird.

Based on this evidence before the panel, on the balance of probabilities, it found this charge proved.

This charge is found proved.

Charge 14d)

On or around 11 January 2018, failed to complete the following documentation for an unknown patient:

d) Nursing assessment

As stated above for charges 14a, b and c, the panel considered the evidence from Witness 10 in relation to her email dated 11 January 2018 and her statement, which highlights the concern that no nursing assessments had been completed. This was reiterated by Witness 1 in his statement and had confirmed this in his oral evidence. The panel also considered Witness 10's oral evidence where she stated that a nursing assessment is also expected to be completed as part of the admission process and must be used as part of the procedure, but this was not carried out by Miss Aird.

Witness 1 also confirmed in his evidence that these are basic nursing assessments, which should have been completed as soon as possible to ensure the right support is provided for the patient and to remain alerted if there is a case of an emergency.

In his statement he stated:

> *'All the basic nursing assessments such as MUST, waterlow, care plans and nursing assessments. She should have done it as soon as possible within reason. If you haven't done a waterlow and it turns out you have a pressure ulcer, that's a risk to the hospital as you cannot prove that it was not the hospital's fault. With the MUST, if they have issues with nutrition be that weightloss* (sic) *or whatever, we need to get the right support in place for them, along with all the normal assessments around mobility and so on.'*

The panel determined that Witness 1 provided a degree of corroboration by explaining how charges 14a-d should have been actioned. Based on this evidence before the panel, which also applies for the charges 14a-c above, on the balance of probabilities, it found this charge proved.

This charge is found proved.

Charge 16

> On or around 11th January 2018, failed to carry out a bladder scan for an unknown patient, following the removal of the patient's catheter

The panel considered the email dated 11 January 2018, which highlights the patient's catheter had been removed but Miss Aird had not completed the bladder scan and was unable to confirm if the patient had urinated. This was reiterated in Witness 1's written evidence and his oral evidence, which corroborates with the concern raised in this charge. He stated that:

> *'She had not done a bladder scan for another patient whose catheter had been removed, and had been unable to say if they had passed urine. If a patient's had a catheter taken out, the only thing we are interested is whether they have urinated and if not, why not and what will be do about it.'*

Witness 1 in his oral evidence, stated he discussed two incidents with Miss Aird, which were the failure to complete admission paperwork and failure to review/carry out a bladder scan for an unknown patient following the removal of the patient's catheter. He stated that the latter incident followed the former incident, which occurred in October 2017.

The panel noted based on the evidence before it that Witness 10 had removed the catheter and completed her handover notes at the end of her shift. It was then Miss Aird's responsibility to carry out the scans. The panel also noted Witness 10's statement where she provided a clear chronology of the incident and this was consistent with her oral evidence. The panel acknowledged that this is further supported by her email to Witness 1 where she stated that Miss Aird was unable to confirm if the patient had passed urine or not and no bladder scan was completed.

Consequently, the panel determined that there was sufficient evidence to prove this charge.

This charge is found proved.

Charge 17)

> On 18 January 2018, told Colleague A that “don’t worry, it’s our secret” or words to that effect when you informed her that she had left a needle in the cannula of an unnamed patient.

The panel accepted the evidence from the meeting notes dated 30 January 2018, which stated that Miss Aird had told the Assistant Practitioner (AP) that she (AP) had left the needle in the cannula. The AP was not convinced about this and reported this to Witness 1, stating that Miss Aird had reportedly told the AP that it would be just between them.

The panel considered Witness 1’s evidence where he confirmed that he was approached by the AP who reported this incident to him. The panel acknowledged that this is hearsay evidence and that there is no documentation or any oral evidence before the panel.

Witness 1 in his evidence stated that the AP approached him directly in relation to this incident as she had concerns about what had been said to her. This matter was raised with Miss Aird during the meeting dated 30 January 2018 and it appears that Miss Aird has not denied that such conversation had taken place. In the file note dated 19 January 2018, Witness 1 stated that he discussed with the AP that Miss Aird claimed she left the needle in the cannula and told the AP “*not to worry, its our secret*” or words to that effect.

The panel held the view that this is an unusual incident and could see no logical reason why an individual would raise this as a concern if it did not happen. The AP appeared so concerned that she raised the matter directly with a senior member of staff, Witness 1 who was the Cath Lab Manager. The panel was of the view that there would be no good reason to report this matter unless it actually happened. The matter was raised with Miss Aird at a meeting with Witness 1 on 30 January 2018 in which there is no record that she denied the allegation in this charge. On the balance of probabilities, it found this charge proved.

This charge is found proved.

Charge 18)

> On 18th January 2018, acted without integrity by failing to complete a datix or make a report to management having disclosed to Colleague A that she had left a needle in the canula of an unnamed patient.

The panel took into account the Witness 1's statement which explains the issue raised in this charge. He stated that if this did happen, this should be reported as a Datix or Miss Aird should have reported it herself by some other means so that it is investigated. He also stated that Miss Aird breached her duty of candour by not reporting errors when they occur.

This matter was raised during the meeting dated 30 January 2018 where Witness 1 had discussed with Miss Aird the incident in relation to this charge. Miss Aird did not deny the incident and the panel determined that as it found charge 17 proved, a reasonable inference could be drawn in that it would seem highly unlikely that Miss Aird would have completed a Datix.

On the balance of probabilities, the panel found this charge proved.

This charge is found proved.

Charge 19

That you, whilst employed by Spire Healthcare as a Registered Nurse between 18 June 2018 to April 2019:

> On 10 July 2018, refused to assist colleague X with a patient/and or drug check when asked.

The panel also considered the email dated 10 July 2018 to Witness 3 from a colleague working with Miss Aird on that day, which provides a full explanation of

what happened on that day and Miss Aird was also asked to not enter the room with her bag over her shoulder. Miss Aird's conduct was described as '*aggressive*', '*unprofessional*', and '*rude*'.

The panel accepted the evidence of Witness 3 who provided an overview of Miss Aird's general behaviour in relation to concerns of poor communication and that when Miss Aird was nearing to end her shift, she would refuse to check medications with a colleague. This corroborates the email mentioned above.

Witness 3 also stated that Miss Aird showed an *'I know best'* attitude and she took the advice provided to her by Witness 3 negatively.

The panel also heard and considered evidence from Witness 2 who stated that when Miss Aird was questioned about leaving her shift on time, her response was that she relied very heavily on her husband to transport her back and forth. The panel was of the view that this corroborates with Witness 3's evidence in relation to Miss Aird finishing her shift exactly on time irrespective of any handover that needed to be completed before leaving her shift.

Witness 6 stated in her evidence stated that Miss Aird was asked by another nurse to administer the diazepam to a patient with her as it required two nurses to administer this medication. According to Witness 6, Miss Aird was 'reluctant' to do so as her 'husband was waiting.' When Miss Aird was asked to sign this medication, she said that she had already signed it but had not signed it properly and instead signed it at 2:30 and not at 7:20. The panel determined that this evidence further confirms the evidence stated above in relation to this charge.

These matters were raised by Witness 2 during the investigation meeting dated 4 December 2018 in which Miss Aird was also present. The panel considered the notes of this meeting including Miss Aird's responses. When Miss Aird was asked about the incident on 10 July 2018 regarding Miss Aird's conduct towards colleagues in front of patients and that she talked "*inappropriately to another member of team about getting off shift*", the panel took into account Miss Airds response where she stated:

"I felt it was unnecessary that the nurse did it that way. In my experience we work as a team to get off shift on time. I also felt that she was ungrateful as I had picked up her patients from recovery with no thanks. There was no respect and no courtesy towards me. I didn't like her manner. We should work together to get people off shift on time."

Having considered all of the evidence together, the panel determined that there is sufficient evidence to find this charge proved on the balance of probabilities.

This charge is found proved.

Charge 20)

On unknown dates between 18 June 2018 to October 2018, took long breaks from the ward without informing your colleagues.

In reaching its decision, the panel took into account Witness 2's evidence where she stated that Miss Aird would tend to 'disappear off the ward' and although she denied this, 'quite a few of her colleagues on several occasions couldn't find her.' Witness 2 also stated in her evidence that Miss Aird was 'missing at various times through a shift.'

The panel also considered the documentary evidence dated 2 November 2018, provided by Witness 5 where she gave specific examples with relevant dates of when Miss Aird was missing from her shifts, which were on 6, 15, 16, 22, 23 and 24 August 2018. On 15 August 2018, Miss Aird had approximately six cigarette breaks during the shift and in her oral evidence, she stated that she heard a staff member who said that Miss Aird was "always out smoking" and that Miss Aird had said "I don't care I am going for a smoke." Witness 5 stated that she heard this personally and found it "shocking."

The statement from the Ward Sister dated 26 November 2018 states that:

‘On numerous occasions, Irene would leave the ward for long periods of time without informing staff members of where she was going or how long she would be.’

Based on the evidence before the panel, on the balance of probabilities, it found this charge proved.

This charge is found proved.

Charge 21

On 24th August 2018, attempted to give a patient Tramadol without checking the patient’s drug chart first.

In reaching its decision, the panel considered Miss Aird’s responses during the investigation meeting dated 4 December 2018 where she explained that she planned to administer Tramadol as the patient was in a *“great deal of pain.”* When asked if she would have given the Tramadol without the chart, Miss Aird stated that sometimes Tramadol is a controlled drug and sometimes it is not.

During that meeting, when Miss Aird was asked why she would not wait for the chart before giving the medication, she stated:

“none of you have been there in these situations. Pictures can be painted. I am fully aware of the drug and how it can be given. I am aware that the drug chart is needed. The patient was in a great deal of pain…I don’t know what else to say. I am fully aware of how the drug is to be given.”

The panel determined that although Miss Aird did not deny about not checking the chart in her response, she did not specifically explain why she did not refer to the chart before attempting to administer the medication.

The panel also considered Witness 5’s evidence where she explained the procedure of how a controlled drug should be administered. She stated that:

"Tramadol is a controlled drug which would require two nurses to sign it out of a locked controlled drug cupboard. Two nurses would then take the prescription and drug to the patient and do checks there."

She further explained that while on the ward accompanying Miss Aird, Miss Aird appeared without the prescription and stated that '*we don't need the script'* and '*will sign it later.'* Witness 5 stated that she informed Miss Aird that she would need to get the chart from the pharmacy and that there was a clear lack of understanding by Miss Aird as to why this needed to happen. Witness 5 confirmed this in her oral evidence where she explained the incident in further detail and that the patient had required a pain relief medication.

The panel on the balance of probabilities, found this charge proved.

This charge is found proved.

Charge 22

On 27th September 2018, gave a patient an incorrect dose of 10mg Oxycontin instead of 5mg.

The panel considered the internal investigation notes where Miss Aird was asked why she did not follow the correct procedure, her response was that there were "*piles of 10s and piles of 5s*" and that "*she did not agree with it".* She also said that there was a change of plan "*last minute"* and within a "*split second and it was gone*." She further explained that:

"*the amount of people who appear when a buzzer goes off. You are made to feel that you have to be doing something or you will be reported. There is no time to do that in an emergency situation you are in."*

The panel also considered Miss Aird's response where she stated that no harm was caused to the patient and that the patient had "*benefitted from it*" and that the

“consultant was happy with it.” The panel acknowledged that Miss Aird accepted that it “was an unfortunate incident.”

A copy of the controlled drugs record was available before the panel in which it considered in reaching its decision. This showed that 10mg of the drug was given instead of 5mg and it showed Miss Aird’s initials against that entry. The panel also considered the Datix Event Management Form, which outlines the account of the incident. Therefore, the panel found this charge proved.

This charge is found proved.

Charge 23)

> On 24th August 2018, did not check the expiration date of paracetamol to be administered intravenously to an unnamed patient before attempting to administer it.

The panel considered the evidence of Witness 5 where she stated that on 24 August 2018, she went into a patient’s room and could see Miss Aird approaching into the room with IV paracetamol. Witness 5 checked the medication and noticed that it was out of date.

In Witness 5’s oral evidence, she stated that she would have expected that Miss Aird would check the expiry date of the medication before bringing it to the patient as it was out of date. This was confirmed by Witness 3 in her statement where she stated that Miss Aird asked Witness 5 to check the paracetamol which on inspection had an expired date. Witness 3 also stated that:

> *“with drugs and your clinical knowledge, you should always be at a level that you understand about your drugs.”*

Based on the evidence above, the panel found this charge proved.

This charge is found proved.

Charge 24)

On 3rd October 2018, wandered off during handover without explanation.

The panel considered the Internal Investigation Report (the Report) dated 15 March 2019, which states that a staff nurse was Miss Aird's mentor on 3, 9 and 22 October 2018. Miss Aird's mentor stated in her internal statement that she "*missed key information regarding patient's recovery including observations and blood results*." She further stated that on handover, Miss Aird would "*occasionally wander off and miss key parts of the patient's information."*

The panel took into account of Miss Aird's mentor's local statement in relation to the internal investigation. She mentions under the dates of 3 and 9 October 2018 references to Miss Aird "*wandering off*" during handovers. The panel considered that the reference under 3 October 2018 directly links to the charge in that she wandered off during handover without explanation and this behaviour is further corroborated by the reference under 9 October 2018.

On the balance of probabilities, the panel found this charge proved.

This charge is found proved.

Charge 25)

On an unknown date in October 2018, removed PCA pump from a patient without consultation with a senior colleague or doctor.

The panel considered the Internal Investigation Meeting Notes dated 4 December 2018 and the Investigation Report dated 15 March 2019 and acknowledged that Miss Aird did not deny that she had removed the PCA pump from a patient without consultation with a senior colleague or doctor. When asked why she disconnected a PCA pump, she responded by saying that she carried out an assessment of the patient and based on her assessment, the patient had a PCA that she did not require. Miss Aird further explained that the patient did not use the pump and did not

appear to be in pain. She also stated that she knew what she needed to do in terms of patient care. When told that it is more about protocol to ask if this is common practice, she accepted this comment but responded by saying that she did "*not put the patient at risk at all."*

Witness 3 in her oral evidence stated that the problem with this is that you are breaking a sterile line. This is consistent with her statement where she stated that this was a clinical failing relating to infection prevention. By breaking the pump line, there could be infection introduced into the line or the patient's cannula. She should have completed the form as this involved a prescription.

The panel also considered the Local Statement of another registered nurse who worked on a shift with Miss Aird. She stated that Miss Aird disconnected the PCA with morphine for a patient that was not under her care without seeking approval. The nurse explained that Miss Aird does not accept criticism and it has been "difficult training her when showing her how to complete duties and the same administrative tasks" these included discharging and admitting patients.

This was corroborated by Witness 3's statement where she stated that Miss Aird had not received the handover for this patient and did not know that the pump was to stay up. Witness 3 also stated that this is poor practice as she had broken and discontinued a sterile infusion line. In this scenario, she should have asked the nurse responsible for the patient and have a brief handover of how they wanted to manage the pump.

On the basis of this evidence, the panel found this charge proved.

This charge is found proved.

Charge 26)

> On an unknown date, did not attend to a cardiac arrest scenario when the emergency bell was called.

The panel took into account the Internal Investigation Meeting Notes dated 4 December 2018 where Miss Aird was asked why she did not attend the cardiac arrest scenario, she responded by saying that she "*did not hear it."*

The panel determined that her response shows that she accepts that she did not attend the cardiac arrest scenario as she did not deny or dispute this during the meeting.

The panel also considered a Local Statement from the Ward Sister who provided details of the concern raised in this charge. She stated that when she asked why Miss Aird did not attend, her response was *"I don't like that kind of thing."*

Witness 5 provided oral evidence to the fact that both her and Miss Aird were on the ward when the alarm was activated. Witness 5 stated that the alarm can be clearly heard throughout the ward.

On the basis of the evidence before it, the panel found this charge proved as Miss Aird did not deny or dispute this concern.

This charge is found proved.

Charges 27a, b and c

> Between 3rd October 2018 to 22nd October 2018, you did not complete the following documents accurately:
>
> a) daily care pathways TG/2
> b) HELP charts TG/2
> c) fluid charts.TG/2

The panel considered the evidence of the Internal Investigation Meeting Notes dated 4 December 2018 where Miss Aird was asked why she failed to complete daily care pathways, HELP and fluid chart on 22 October 2018, her response was that the paperwork was not brought to her. She also stated that her colleague agreed with

her in that it was slightly unfair that she was supernumerary and that her mentor should have been mentoring her.

The panel also considered the local statement from a nurse who worked with Miss Aird on the dates referred to in this charge. She stated that on 9 October 2018 and 22 October 2018, Miss Aird was aware that she failed to complete the care pathways, HELP charts and fluid charts.

A local statement from the Ward Sister stated that upon discharging the patient, the care pathway was “blank”. The panel acknowledged that there is no date for when this happened, but it was of the view that it corroborates with the nurse’s local statement regarding this matter and that Miss Aird did not complete the forms properly.

The panel determined that Miss Aird did not deny this charge when questioned during the meeting. Instead, she provided reasons as to why she did not complete those records. In light of the evidence before the panel, it found charges 27a, b and c proved.

This charge is found proved.

Charge 27d

> Between 3rd October 2018 to 22nd October 2018, you did not complete the following documents accurately:
>
> d) NEWS chart TG/2

The panel considered Witness 3’s oral evidence where she stated that NEWS is used throughout the National Health Service (NHS) but agreed that it was not used throughout the entire NHS. She also stated that it does not take very long to complete it and it would only take a few days to train a healthcare assistant for this.

In the Internal Investigation Meeting Notes 4 December 2018, the panel noted that Miss Aird accepted that she was aware of the NEWS training and had completed this. The panel also noted that she completed her PIP on 17 September 2018 and based on the PIP form, it shows that Miss Aird had not completed the NEWS chart in entirety. The panel acknowledged that the PIP form covered the dates between 17 September to 29 November 2018 and the PIP review meeting covered the period from 17 September to 29 November 2018.

In the second PIP form (Progress Review Meeting) dated 5 October 2018, it shows that Miss Aird had signed this on 22 October 2018 and was signed on 5 October 2018 by her manager. This form also shows that there were no omissions in relation to NEWS charts and was completed correctly.

Therefore, the panel determined that any concern for the completion of the NEWS charts were not during the period stated in charge 27. There were concerns that she had not completed the chart. The panel acknowledged that it is likely that the NEWS chart was not completed.

The panel also determined that if Miss Aird claimed that she does not know how to complete the NEWS charts despite being trained, then it could be reasonably inferred she did not complete the NEWS charts considering she found them difficult. The panel acknowledged that there were no issues between 17 September 2018 and 5 October according to the review form as it was recorded as no omissions with NEWS completion and was completed correctly.

However, the local statement of a Recovery Unit Sister stated that there are incorrect NEWS scores on more than one occasion. The panel determined that there are no specific dates mentioned and no other evidence to state that the NEWS charts were not completed between the 3 and 22 October 2018 as referred to in this charge. Therefore, the panel found this charge not proved.

This charge is found NOT proved.

Charge 28)

> On an unknown date, documented a ‘ready for discharge time’ on the recovery pathway before the patient was admitted.

The panel considered the Spire Anaesthesia Recovery Form completed by Miss Aird and it determined that it is clear that the time entered for discharge is prior to the time admitted. Miss Aird has not denied or disputed this during the internal investigation interview. Therefore, the panel found this charge proved.

This charge is found proved.

Charge 29)

> On 6th October 2018, did not check a patient’s drug chart and put eye drops into the wrong eye of an unnamed patient.

The panel considered the Internal Investigation Meeting Notes dated 4 December 2018 where Miss Aird was asked about inserting eye drops in the wrong eye and why she did not check the chart, Miss Aird admitted that she did not look at the prescription. She stated that the patient knew which side they are having done and that she dilated that eye. Miss Aird also stated that she reported this to Witness 3 and accepted that she should have looked at the prescription and has learnt from this.

Witness 3 in her statement stated that when she spoke to Miss Aird about inserting the eye drops into the patient’s wrong eye, Miss Aird stated that she struggled with left and right and did not read the prescription.

The panel considered the local statement by the nurse who worked with Miss Aird on the same shift and stated that a patient’s premedication eye drops were incorrectly put in the wrong eye despite being accurately highlighted on the booking form and medication chart. This was also referenced on the PIP form. In light of the evidence before the panel, it found this charge proved.

This charge is found proved.

Charge 31)

> On the 22nd October 2018, you failed to administer Lansoprazole to an unknown patient.

In reaching its decision, the panel considered the Internal Investigation Meeting Notes 4 December 2018 where Miss Aird admitted that she did not know much about the lansoprazole and did not know there is an issue about it. The panel also considered the local statement provided by Miss Aird's mentor on 22 October 2018. She stated that this medication was not administered to the patient which was questioned by the consultant. This was reiterated in her email dated 30 October 2018 where she stated that medications were not administered as prescribed and this was raised by other staff over the "last month" so these were not new issues and no improvements were made. The panel was of the view that this corroborates with the local statement.

The panel determined that Miss Aird admitted that she did not know much about the drug and that she did not deny this charge. Therefore, the panel found this charge proved.

This charge is found proved.

Charge 32)

> On the 25th October 2018, did not communicate to your colleagues when you did not administer drugs to patients on your drug round.

On 25 October 2018, a nurse was assigned to work in level 3 team 2 with Miss Aird and to provide supervision. The supervising nurse stated that there were times where Miss Aird did not communicate that a certain drug had not been administered and hence there could have been a delay and cause a risk of non-administration if not checked. The panel determined that as this nurse was the supervisor and a witness of the incident on the day, this is sufficient evidence to prove the charge.

The panel also determined that Witness 3's statement corroborates the evidence provided by the supervising staff nurse in relation to Miss Aird not communicating with her colleagues when she did not administer the drugs to the patients during drug round.

This charge is found proved.

Charge 33)

> On an unknown date, did not know how to treat a patient having a vaso vagal attack

The panel noted that in the Internal Investigation Meeting Notes 4 December 2018, Miss Aird was asked about not treating the patient who had a vasovagal attack. She stated that the patient did not need fluids and that she had finished her shift. The panel acknowledged that although this was a vague response, Miss Aird did not deny this allegation.

The panel also considered the evidence of Witness 5 who stated that Miss Aird went to get fluids which were not prescribed and the patient was clearly suffering a vasovagal episode. She also stated that Miss Aird did not know how to deal with a "simple thing" and it is a common occurrence for a nurse that someone may feel faint, and she did not have knowledge of what to do." Witness 5 also reiterated this in her oral evidence where she stated that it was evident on entering the room that the patient was having a vasovagal attack as the patient was extremely pale and unconscious. She explained that someone with Miss Aird's experience should have known that this was happening and she should have dealt with this issue. This is reiterated in Witness 5's local statement, which corroborates and remains consistent with the other evidence before the panel.

Therefore, on the balance of probabilities, the panel found this charge proved.

This charge is found proved.

Charge 34)

> On an unknown date, tried to mobilise a post hip operation patient on your own without a colleague.

The panel considered the local statement provided by Witness 5 who stated that Miss Aird had mobilised a post hip operation patient by herself on Wednesday 15 August. In the Internal Investigation Meeting Notes (the Internal Interview) 4 December 2018, the panel noted that Miss Aird was aware that there is a two people policy for post hip operation patients. She accepted that she helped somebody up and that she was new on the ward at the time. She also clarified in her response that she was certain that a post hip operation patient cannot be assisted by one person. The panel determined that Miss Aird based on her response during the internal interview, has admitted to this charge and having considered the local statement provided by Witness 5, corroborates the matter raised before the panel and it found this charge proved.

This charge is found proved.

Charge 35)

> "On an unknown date, failed to give an unnamed patient the full dose of Intravenous Cyclizine"

The panel considered Witness 3's evidence where she stated that the Recovery Sister had concerns about the drug cyclizine as this is supposed to be given as a "*slow IV injection and not a drug in recovery which would be titrated which is what Miss Aird was doing*". She stated that Miss Aird did not seem to understand what she had done wrong and was surprised about this as her background was recovery and this would have been common practice.

The Recovery Sister in her local statement stated that Miss Aird did not give the complete dose of cyclizine IV. She stated that when Miss Aird was questioned about this, her response was:

> *"the patient did not feel nauseated anymore and so did not need anymore (sic)."*

The Recovery Sister stated that this needed to be administered in accordance with the prescription and it is not a drug that can be titrated.

In the Internal Interview dated 4 December 2018, when Miss Aird was asked why she decided to do this without checking with the nurse in charge first, she stated that she had given cyclizine for *"many years"* and that the policy says to give the drug within 10 minutes… "*perhaps I should have copies of your policies in my pocket!"* The panel was of the view that this suggests a repeated attitudinal issue.

On the basis of the local statement by the Recovery Sister who witnessed the incident, the panel found this charge proved.

This charge is found proved.

Charge 36)

Failed to complete drug rounds in a timely manner throughout your period of supervision.

The panel took into account the Internal Interview dated 4 December 2018 where Miss Aird was asked if she took longer than others to complete drug rounds, her response was:

"perhaps, I don't know."

The panel were of the view that "timely manner" is a subjective matter and there is no evidence of the specific time taken by Miss Aird or any comparison of what a typical time would take as a professional nurse.

The panel determined that the NMC has failed to provide any explanation as to how long a timely drug round would take. It was of the view that there does not seem to be any evidence where this issue was raised to Miss Aird in terms of her practice and the NMC has not proven its case. Therefore, the panel found this charge not proved.

This charge is found NOT proved.

Charge 37)

> Between 9th October 2018 and 22nd October 2018, failed to complete your mandatory training as requested.

The panel took into account Witness 5's statement where she stated that online mandatory training was not completed as she was halfway through controlled drug training and the NEWS module, but there are 26 modules for the mandatory training. This was also confirmed in her oral evidence.

The panel also considered Witness 6's statement where she stated that Miss Aird was allocated some time to complete her mandatory training but she only completed 23%. The panel was of the view that this supported the fact that Miss Aird was provided time off to complete the training required. The panel determined that Miss Aird was provided with an opportunity to compete the mandatory training. The panel noted that Witness 6 also confirmed this in her oral evidence, which remained consistent with the evidence before the panel.

The panel viewed the evidence of Miss Aird's mentor's local statement where she stated that she worked with Miss Aird on 3 October 2018 and discussed Miss Aird's training with her. She stated that Miss Aird was aware of the need to complete her online training as part of her PIP and her role as a nurse. She also stated that Miss Aird was offered several opportunities to complete this but did not do so as required. She further stated that on 9 October 2018, she had asked Miss Aird to complete her online training and had offered her the time and opportunity to do so. Miss Aird was also provided a link to access the training from home as an alternative in case this was a better option for her, but "*she would wander off and again did not complete her training."*

Similarly, another nurse provided a local statement and stated that on 22 October 2018, Miss Aird did not complete her online training nor was it accessed.

On the basis of the evidence considered above, the panel found this charge proved.

This charge is found proved.

Charge 38)

That you, whilst employed by Dussindale Care Home as a Registered Nurse on 20 to 21 October 2018:

> Dispensed and/or administered 10 extra tablets of paracetamol for an unnamed patient.

The panel considered the evidence of Witness 7 who stated that 10 tablets of paracetamol were missing. This was confirmed in her oral evidence and stated that Miss Aird was responsible for the residents as she was the only nurse in charge on that day. She also confirmed in her oral evidence that it would only be the nurse in charge who would be administering the medications.

In the email sent from Witness 7 dated 25 October 2018 which states that the shifts on 20 and 21 October 2018, 10 tablets of paracetamol were missing in room 6.

The panel also viewed the Medication Error/Incident Reporting Form dated 20 and 21 October 2018, which explained that on 20 October 2018, the medication is prescribed to be taken as required (PRN) admin record, it showed two tablets were given leaving 78 tablets in stock. It was also found that there were three signatures but only two tablets were dispensed. No entries were made on the PRN admin record sheet and Witness 7 assessed that there was one dose of 1 paracetamol tablet signed for but not given. Based on these findings, Witness 7 concluded that 10 paracetamol tablets were missing.

Witness 7 confirmed in her oral evidence that Miss Aird was the only nurse on duty during 20 and 21October 2018. Due to the concerns about the administration of the drugs over the weekend, Witness 7 carried out an internal investigation to check this issue. It was then found that there were numerous errors of the amount of drugs administered over the course of that weekend. Therefore, Witness 7 confirmed that

Miss Aird was the responsible nurse in charge and was the only person with access to the drugs. Therefore, the panel found this charge proved.

This charge is found proved.

Charge 39a-c

Did not administer a dose of Levetiracetam 1g tablet to an unnamed patient on the following dates:

a) 20 October 2018, PM
b) 21 October 2018, AM
c) 21 October 2018, PM

The panel considered the evidence of Witness 7 in her email dated 25 October 2018, where she stated that three doses of leviteracetam 1g tablets were not administered to the patient in room 22 on Saturday pm, Sunday am and Sunday pm. Witness 7 stated that 1mg leviteracetam should have been administered during the morning and the afternoon of the Saturday and Sunday and that all four doses were not signed.

In Witness 7's Medication Error/ Incident Reporting Form dated 20 and 21 October 2018, it states that leviteracetam 1g tablet was prescribed but there were missing signatures for doses on both 20 and 21 October 2018. She further stated that four tablets should have been dispensed over the weekend but stock checks show only one had been used. This was the Saturday am dose which was administered in company of another nurse. Miss Aird was made aware of this issue on Sunday afternoon regarding the missing signatures in the MAR chart but Miss Aird stated that the medications had been given and that this was an oversight. Miss Aird stated that she would sign the MAR chart before leaving her shift on Sunday, but she did not. Witness 7 on the basis of her findings, concluded that three doses of leviteracetam 1g tablets were not given on Saturday pm, Sunday am and Sunday pm.

In her oral evidence, she confirmed that when the investigations concluded, the medications were given but not signed for and the MAR chart was not completed correctly. However, the panel noted Witness 7 was giving oral evidence 5 years after the event and preferred the evidence of the Medication Error/ Incident Reporting Form dated 20 and 21 October 2018, produced by Witness 7 as it was closer to the timing of the incident and it states that only one of the drugs were dispensed.

Additionally, the panel considered the handwritten statement dated 31 Oct 2018 by Miss Aird, where she referred to the patient in room 22. She stated:

> '*This ladies room I believe tucked away round the corner and the other nurse said to me that she wasn't on any tablets. As this was the last patient I saw her picture but obviously I should have checked. As this is 2 days running, this is the only explanation.'*

The panel determined that this response suggests that she had missed that patient. Based on the evidence considered above, the panel found that the medication was unlikely to have been dispensed and found charges 39a-c proved.

Charges 39a-c are found proved.

Charge 40

> Signed the MAR chart of an unnamed patient to record paracetamol had been administered when you did not administer to said patient.

The panel considered Witness 7's email dated 25 October 2018 which refers to room 5 where only one dose of paracetamol was signed for but not administered to the patient.

In the Medication Error/ Incident Reporting Form dated 20 and 21 October 2018 (Incident Report Form), written by Witness 7, which explained that the medication administration documentation showed three signatures, which suggests that three paracetamol tablets should be administered. However, stock checks showed that

only two tablets were dispensed. Therefore, one tablet was signed for but was not dispensed.

In Witness 7's statement, she explained how the medication errors were discovered, that Miss Aird was alone on shift and Witness 7 was the first person that this issue was reported to who then proceeded with an internal investigation of the issue. She found that there were 20 or more errors but that most of them were missing signatures or admitted to recording the PRN extra chart record.

In her oral evidence, Witness 7 stated that Miss Aird was solely responsible for the administration of the medications that weekend during 20 and 21 October 2018. The panel noted that it had not seen the MAR charts and it was satisfied that Witness 7's evidence was credible. The panel determined there is sufficient contemporaneous documentary evidence corroborated by Witness 7's oral evidence and this accurately reflects the administration and recording of the medication.

This charge is found proved.

Charge 41)

> On 21 October 2018, signed the MAR chart of an unnamed patient to record Pregablin had been administered when you did not administer to said patient.

The panel considered Witness 7's email dated 25 October 2018 where she made reference to pregabalin and stated that this was signed for but not given to the patient in room 7 on 21 October 2018.

In the Incident Report Form, Witness 7 stated that one capsule was omitted on Saturday due to sleepiness and this was found in the blister. One tablet was also found in the blister for Sunday, which was not signed for. Based on this evidence, pregabalin was signed for but not given on 21 Oct 2018.

The panel further considered Miss Aird's written statement dated 31 October 2018 in response to the internal investigations where she stated that the pregabalin must have

> *"got stuck in the packet as when I gave the tablets, I pushed each one out onto my hand then put them in the pot."*

On the basis of the evidence before it, the panel found this charge proved.

This charge is found proved.

Charge 42)

> On 21 October 2018, signed the MAR chart of an unnamed patient to record Sodium Valporate 200mg was administered but you did not administer to said patient.

The panel considered the same evidence as referred to in Charge 41 and found that sodium valproate was signed for but not given to the patient on 21 October 2018.

In Miss Aird's email dated 01 November 2018, she stated that she made sure that the patient received the sodium valproate as she knew how "*essential it is*."

The panel determined that on the balance of probabilities, it accepted the evidence provided by Witness 7 in that the drug was signed for but not administered as Miss Aird's account of the event in her email and her handwritten statement were contradictory. In her email, she claimed that the patient was "*feeling sick*" but she made sure the patient had the medication. However, in her handwritten statement she claims that the medication:

> *"got stuck in the packet as when I gave the tablets, I pushed each one out onto my hand then put them in the pot."*

On the basis of the evidence before it, the panel found this charge proved.

This charge is found proved.

Charge 43

> On 21st October 2018, did not sign an unnamed patient's MAR chart to record that Metformin and Quetiapine was administered to said patient.

As stated in Charge 40, the panel considered Witness 7's statement which set out the incidents that occurred on 21 October 2018 and what action was taken as soon this was reported to her.

The Incident Report Form produced by Witness 7 referenced room 10 where it was found that there were missing signatures for metformin and quetiapine but appeared to be dispensed with no errors identified. Therefore, Witness 7 stated that Miss Aird did not sign to record the drugs, but it was administered to the patient.

The panel considered the handwritten statement by Miss Aird where she stated that there were two missing signatures and that she should have documented this as "N" but decided to carry out observations and measure the patient's blood pressure, pulse and temperature. The panel noted that this does not provide a clear explanation as to why she did not record this in the MAR chart but acknowledged that she accepted her mistake in that she should have documented it. It therefore determined that Witness 7's oral evidence was sufficient to show that the drugs were administered but not signed for.

On the balance of probabilities, the panel found this charge is proved.

This charge is found proved.

Charge 44

On 20 October 2018, signed an unnamed patient's MAR chart to record Apixaban 2.5mg was administered but you did not administer to said patient.

The panel considered the same evidence referenced in Charge 43. It considered the email sent from Witness 7 dated 25 October 2018 which referred to Apixaban 2.5mg and stated that this was signed for but not administered to the patient on 20 October 2018. Witness 7 in her Incident Report Form stated that this tablet was found in blister and therefore on that basis, concluded that Apixaban 2.5mg was signed for but not given on 20 October 2018.

The panel noted Miss Aird's response in her handwritten statement where she stated that the patient had only one tablet and that she must have signed it before dispensing the medication. The panel determined that this suggests that she signed for it but did not administer the medication and on that basis, it found this charge proved.

This charge is found proved.

Charge 45

On 20 October 2018 and/or 21st October 2018, signed an unnamed patient's MAR chart to record that Laxido was administered but you did not administer to said patient.

The panel considered Witness 7's email regarding the issue raised in this charge, which stated that laxido was not administered on one day as prescribed. Similarly, in the Incident Report Form produced by Witness 7, it stated that the laxido sachet was not signed for on Saturday or Sunday, but one sachet was missing. On that basis, Witness 7 concluded that laxido was not given on one day as prescribed.

In relation to the handwritten statement by Miss Aird in response to this issue, she stated that the patient had one sachet in his drawer beside him and that she told him to take that one. The panel acknowledged Miss Aird's response but noted that there is no evidence to show that this medication was administered on 20 or 21 October

2018 nor is there any signature to show that this medication was dispensed. Therefore, on the balance of probabilities, the panel found this charge proved.

This charge is found proved.

Charge 46

> On 21 October 2018, signed an unnamed patient's MAR chart that 3 tablets of codeine 30mg was administered but you did not administer to said patient.

The panel considered the email sent from Witness 7 which stated that three tablets of Codeine 30mg was signed for but not administered on 21 October 2018 and in her Incident Report Form, she stated that the patient was prescribed 30mg of Codeine of one or two tablets PRN up to four times day (QDS). Witness 7 further explained in the Incident Report Form that Miss Aird signed for three tablets on Sunday but after stock checks were completed, it was found that no tablets had been taken from the box. It was reported by the patient that she did not have the right amount of medications over the weekend although it was not clear which tablets or which day this was. Witness 7 concluded that three tablets of Codeine was signed for but not administered to the patient on 21 October 2018.

The panel took into account Miss Aird's response in her statement where she stated that she would have taken the drug from another box and that she remembered taking a new box out of the cupboard and "*started it."* The panel determined that this was not a clear explanation in relation to the incident.

The panel decided that this charge is found proved on the basis of the evidence which shows that the drugs had not been administered to the patient. Although the panel acknowledged Miss Aird's response in that she took the medication out of the cupboard, the panel was of the view that the documentary evidence referring to the stock checks suggest that they are still present and therefore not administered. On that basis, the panel found this charge proved.

This charge is found proved.

Charge 47

On 20 October 2018, did not sign the MAR chart following the administration of **Levetiracetam** 1g for an unnamed patient.

As stated in Charge 39a-c, the panel considered the same evidence referred to in that charge and determined on the same reasons as stated above.

Having considered the email and the Incident Report Form produced by Witness 7, it determined that there was sufficient evidence to show that the MAR chart for this drug was not signed. Therefore, it found this charge proved.

This charge is found proved.

Charge 48

Failed to complete the PRN charts for all patients on both shifts despite a request from colleague X.

This charge is proved to the extent that the panel are satisfied on the balance of probabilities that Miss Aird failed to complete the PRN charts for some but not all patients on both shifts. This is reflected in the email produced by Witness 7 dated 25 October 2018, which lists all of the errors for each medication.

In the Incident Report Form written by Witness 7, it states that the Deputy Manager attended on Sunday morning and noticed some missing signatures from the MAR charts and having returned on Monday morning, the Deputy Manager found that there were still missing signatures.

In Witness 7's statement, she explained that she had confronted Miss Aird about the PRN chart and the missing signatures. She stated that Miss Aird became defensive but apologetic at the same time. She explained that Miss Aird stated that she did not realise and would complete them before she left her shift. Witness 7 also confirmed this in her oral evidence and further explained that when she returned to the Home

on Monday, she found that Miss Aird only completed one or two but not for all the patients.

The panel noted in Witness 7's evidence where she stated that there were two PRN errors in room 6 and in room 21, three tablets were not signed for which was discussed with Miss Aird on Sunday.

Based on the email sent from Witness 7 in relation to a record of medication errors on shifts 20 and 21 October 2018 and the statement provided by Witness 7, the panel determined that Miss Aird had failed to complete the PRN chart for some patients on both shifts despite being asked to complete them by the Deputy Manager. Therefore, it found this charge proved.

This charge is found proved.

Charge 49

That you, whilst employed by Two Acres Care Home as a Registered Nurse between 6 February 2020 to 18 February 2020:

> On 15th February 2020, failed to sign an unknown patient's MAR chart, following an administration of calcit -D to said patient.

The panel considered the evidence of Witness 9 who stated that:

> *'Calcit-D3 was administered on the 15th but signature missing, all the morning medications on the 17th were signed with "G" (once again to signal refusal) but as you follow the numbers on the "remaining balance" you can see that the medication was never dispensed. This suggests that I.A had approached the resident and asked if they would like to take their medication but the resident declined.'*

The panel also considered the MAR charts dated between 10 February 2020 and 8 March 2020, which corroborates Witness 9's evidence in his statement.

The panel noted from the MAR chart that 15 February 2020 was highlighted and can be seen that the medication was reduced by 1 tablet and signatures cannot be seen in the signature box. All other entries show signatures in the signature box apart from 15 February 2020.

Witness 9 in his oral evidence confirmed that the unit is large and was divided into "two wings" with one nurse working on each side between 6-18 February 2020. He stated that Miss Aird was responsible for this side which included this particular patient.

Therefore, on the balance of probabilities, the panel found that the medication was administered to the patient but not signed for.

This charge is found proved.

Charge 50)

> On 17th February 2020, signed to record on an unnamed patient's MAR chart that Rivaroxaban was administered before you had administered such to that patient.

In reaching its decision, the panel considered the MAR charts, Witness 9's statement and Miss Aird's reflective statement.

The panel acknowledged Witness 9's statement where he clarified that 'G' means it has been refused. This was also confirmed in his oral evidence.

Witness 9 further mentioned that Miss Aird was permitted carry out medication rounds under direct supervision as part of her induction, but it was noted that multiple signatures were missing and some signatures were crossed out with a "G" written underneath. The overleaf read, *'refused medication'*.

In relation to the MAR chart before the panel, it could be seen that on 17 February 2018, Miss Aird has signed the entry showing that she has administered the medication and a “G” added afterwards to show it was refused by the patient. This was corroborated by Witness 9’s evidence including his oral evidence to the panel. The panel determined that this suggests that the chart was signed by Miss Aird before she administered the medication, even though the medication was refused by the patient.

The panel acknowledged Miss Aird’s reflective statement where she explained the procedure for administering medications in the way she was taught. She stated that she would remove the tablets and ensure that everything was correct for the patient and then sign the chart to confirm that she had administered the medication. She further stated that the Home was doing it as per the Boots model, which was not to sign the medication that was administered, but to sign when the medication was taken by the patient.

The panel determined that this is consistent with the evidence of Witness 9 and the MAR chart before the panel. Therefore, the panel found this charge proved.

This charge is found proved.

Charge 51a)

> On 17th February 2020, signed to record that the following medications were administered to an unnamed patient but you did not administer to said patient:
>
> a) Laxido orange oral powder

The panel considered the MAR charts and noted that the entry dated 17 February 2020 shows the letter “G” and that the balance of sachets for laxido is at “9” and appears to be the same on 16 February 2020.

Therefore, the panel determined that Miss Aird took the sachet to the patient who refused to take the medication and Miss Aird then put a “G” on the entry of the MAR chart to show that Miss Aird attempted to administer the medication to the patient, but this was refused. Therefore, Miss Aird did not sign the MAR chart and the panel found this charge not proved.

This charge is found NOT proved.

Charge 51b

> On 17th February 2020, signed to record that the following medications were administered to an unnamed patient but you did not administer to said patient:
>
> b) Folic acid 5mg

Similar to charge 51a, the panel considered the MAR charts and noted that the entry dated 17 February 2020 shows the letter “G” and that the balance of sachets for folic acid is at “18” and appears to be the same on 16 February 2020.

Therefore, the panel determined that Miss Aird took the sachet to the patient who refused to take the medication and Miss Aird then put a “G” on the entry of the MAR chart to show that Miss Aird attempted to administer the medication to the patient, but this was refused. Therefore, Miss Aird did not sign the MAR chart and the panel found this charge not proved.

This charge is found NOT proved.

Charge 51c

> On 17th February 2020, signed to record that the following medications were administered to an unnamed patient but you did not administer to said patient:
>
> c) oxybutynin 5mg

Based on the evidence before it, the panel acknowledged that the tablets were prescribed to be administered twice a day. On the MAR chart, it appeared to show that on 16 February 2020 there were 43 tablets and on 17 February 2020, there were 42 and the following day there were still 42 tablets remaining.

The panel determined that it is evident from the MAR chart that the stock balance for the medication is reduced on 17 February 2020. It was of the view that the MAR chart shows that the stock balance was not reduced on 16 February 2020 and that if this was administered, the stock balance would have been reduced. The panel noted that this does not follow the pattern of the other days in the chart and that there is a "G" on the top of the column with no signature which shows that the patient refused the medication. The panel determined that Miss Aird did not sign the MAR chart as it was not administered to the patient. Therefore, the panel found this charge not proved.

This charge is found NOT proved.

Charge 52)

> "On 18th February 2020, signed to record on an unnamed patient's MAR chart that medication had been administered before you had administered it."

The panel took into account the evidence of Witness 8 who stated that when she asked Miss Aird why she signed the MAR chart first, Miss Aird responded by saying that this is how she had always done it everywhere she worked. The panel noted that Witness 8 was a training coordinator and was there to witness Miss Aird during that drug round.

The panel determined that Witness 8 was clear, corroborating her statement regarding how Miss Aird administered the medication. The panel did not have access to the relevant MAR chart. However, it was satisfied from Witness 8's NMC Statement, Local Statement and her oral evidence, together with Miss Aird's note in her Reflective Statement explaining that she always signed the chart before administering the medications, that there was sufficient evidence to prove this charge. Therefore, on the balance of probabilities, the panel found this charge proved.

This charge is found proved.

Charge 53

> On 18th February 2020, stated to colleague B that ‘everywhere you had worked, you signed first’ or words to that effect.

The panel considered the evidence of Witness 8 as stated in charge 52 and her Local Statement in relation to this charge. Witness 8 in her statement stated that she would not be happy to sign any competencies at this time. Miss Aird told her that she would comply with signing for medication following administration but she still felt that it was unsafe and that she had never worked anywhere that practised this way.

The panel acknowledged Miss Aird’s response in her reflective statement where she stated that she always signed first, which supported Witness 8’s evidence. On the balance of probabilities, the panel found this charge proved.

This charge is found proved.

Charge 54

> “On 18th February 2020, you told colleague C “Never had to wait for the patient to take the tablet before signing the administration chart. Not in any previous workplace” or words to that effect.”

The panel considered the Local Statement provided by Witness 9. In that statement, he stated that he had a telephone discussion with Miss Aird where he told her not to return to work on the following day due to the issues raised and feedback from other nurses. Witness 9 in his oral evidence stated that this statement had been completed the day following the phone call (19 February 2020). The panel noted Miss Aird’s response where she said, *“just because I missed a signature.”*

Witness 9 stated that this was not the only issue and Miss Aird could not understand the problem and stated that Miss Aird said she never had to wait for a patient to take the tablet before signing the administration chart in any previous workplace. Witness 9 stated that this was not only the Home's policy but also an NMC requirement that is well known by all registered nurses.

The panel also noted Miss Aird's reflective statement where she stated:

> *'It has since been bought to my attention that I did not access the policies whilst I worked at 2 Acres. I understand that this is something I should have done prior to commencing employment or at least familiarised myself with at the beginning. I do not want to make any excuses for this as I do believe it would have helped but I thought at the time that the boots medication training would cover everything I needed to know initially. In hindsight, I should have read through everything to gain an understanding of the way the Home liked to have things done. Particularly as it was different to any setting I had worked in full time before and that this area of my practice needed improvement. I am very sorry for not accessing it and I know that in the future this is something I would definitely do. When I obtain a nursing role, I will ensure that I access and read the policies and complete training in an efficient manner. That way, if I have any problems, I can query these and ensure I am up to speed before starting work.'*

In light of the evidence above, the panel determined that this charge is found proved.

This charge is found proved.

Charge 55

> Your actions at charges 53) and/or 54) was dishonest as you sought to provide a misleading account of your work experience to justify your actions.

The panel acknowledged the Certificate of Safe Administration of Medicines, which shows Miss Aird achieved 93% in this training module dated 30 November 2018,

although this incident occurred in 2020. The panel noted that this included training on Medication Record Entries and Medication Administration Records.

The panel noted that it remains unclear as to what this course would have taught in relation to how medications should be administered, but based on what was heard from Witnesses, they supported the allegations charged. This was contrary to Miss Aird's account of the events and the method she used to administer the medications despite having completed this certificate and her claim that the Boots training was not the correct procedure to administer medications.

Miss Aird remained adamant that her method of dispensing and administering medications was correct. The panel considered that this was likely to be contrary to the training she has undertaken throughout her nursing career. The panel formed the view that the only explanation for Miss Aird's actions was to mislead colleagues that her methods and practices in relation to dispensing and administering medications was accepted practice at all of her previous areas of employment. The panel did not find this a creditable proposition, therefore found the charge proven.

This charge 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 Miss Aird'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, Miss Aird's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Chapman provided written submissions in relation to misconduct and impairment as follows:

> *'The panel have found charges 1, 2, 3 a-c, 6, 7, 9, 12, 13, 14 a-d, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 a-c, 28, 29, 31, 32, 33, 34, 35, 37, 38, 39 a – c, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, and 55 proved.*
>
> *The panel have found charges 4, 5, 10, 11, 27 d, 36, and 51 a - c not proved.*
>
> *Charges 8, 15 and 30 were deleted/withdrawn.*
>
> *It is submitted on behalf of the NMC, that the actions of R, in the context of the charges found proved, amount to misconduct.*
>
> *It is further submitted that R's fitness to practice is currently impaired by reason of that misconduct.*
>
> *The law and guidance*
>
> *Misconduct*
> *There is no universal statutory definition of misconduct, and so the definition is taken from caselaw.*
>
> *Roylance v General Medical Council [1999] UKPC*

In the case of Roylance it was held that misconduct involved acts or omissions which fell short of what was proper in the circumstances.

Furthermore, the above case establishes that it must be serious, and it must be connected to the profession; although the panel should note that conduct removed from medical practice, and even administrative conduct, can still amount to misconduct for the purposes of these proceedings if it was sufficiently immoral, outrageous or disgraceful in character.

In the present case, it is submitted that R's conduct consisted of positive acts and omissions which fell short.

Seriousness

The NMC refers the panel to the NMC Guidance on 'Seriousness'. In particular, the panel are referred to the section titled: 'Serious concerns which could result in harm to patients if not put right'.

R (Remedy UK Ltd) v General Medical Council [2010] EWHC 1245

In the above case, it was held that the conduct must be "sufficiently serious that it can properly be described as misconduct going to fitness to practise".

The case also established that not all acts and omissions will be regulatory matters. At paragraph 37 of the judgment, the case defined misconduct as being of 'two principles kinds':

> *"First, it may involve sufficient serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession."*

It is submitted that in the present case, the former applies, the charges having arisen from R's clinical practice.

Nandi v General Medical Council [2004] EWHC 2317 (Admin)

At paragraph 31 of the above case, Roylands was reaffirmed, and it was also held that, "the adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners."

In relation to the charges found proved relating to clinical failures, it is submitted that these acts alone amount to "sufficiently serious misconduct''. R's actions caused patients to be harmed and/or placed at risk of harm. Harm is further addressed at paragraph 31 onwards.

The charges are even more serious when taken together with charges 18 and 55, where dishonesty and a failure to act with honesty and integrity were found proved.

It is submitted that an additional consequence of the dishonesty element, is that it placed or places colleagues in difficult positions insofar as they are not able to trust or rely on the candour or honesty of R, and there is a risk that this would have an impact on the care they receive or deliver.

It is submitted therefore the registrant's actions did amount to sufficiently serious misconduct for the purposes of these proceedings.'

Submissions on impairment

Ms Chapman 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. She provided her written submissions as follows:

Impairment

There is no specific definition of impairment, however there is a body of caselaw which assists, as does the NMC guidance on "impairment", which the panel are referred to.

The NMC's guidance states:

> *"The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

The panel will consider whether, by reason of the misconduct or some other reason, there is an unwarranted risk to patient and public safety that is ongoing if R were able to practice without restriction.

Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin)

Grant clarifies on what grounds impairment can be found, at para [76]:

> *'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.'*

As set out in these submissions, it is submitted by the NMC that there is an unwarranted risk to patient and public safety by virtue of R's clinical failings and dishonesty.

It is further submitted that R's actions breached the trust the public and patients place in the profession and a finding of impairment is warranted on these grounds.

Paragraph 76 of Grant goes on to clarify the following test:

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

The NMC submits that each of the above criteria is satisfied.

<u>Insight</u>

The panel may be assisted by the NMC Guidance titled 'Insight and strengthened practice' which sets out the factors to be considered. The guidance states:

> *"When assessing evidence of the nurse, midwife or nursing associate's insight and the steps they have taken to strengthen their practice, decision makers will need to take into account the following questions:*
>
> *Can the concern be addressed?*
>
> *Has the concern been addressed?*
>
> *Is it highly unlikely that the conduct will be repeated?*
>
> *These factors are key points for decision makers to consider, but they are not a definitive test of whether a nurse, midwife or nursing associate's fitness to practise is currently impaired".*

The panel may be further assisted by the guidance which is titled 'Has the concern been addressed?' Which outlines some non-exhaustive factors that the panel may feel demonstrate whether or not concerns have been addressed.

<u>The present case</u>

In the present case, that the actions or acts of R were multiple, sustained clinical failings despite intensive support and supervision, compounded by serious underlying attitudinal issues.

Further, that R acted without integrity by attempting to dissuade a colleague from reporting that colleague's error nor escalating the issue as she was bound to do (charges 17 & 18), and was dishonest by providing a misleading account of R's own work experience to justify her performance (charges 53 - 55).

Public protection

R's acts and omissions put patients at risk of serious harm. R failed on multiple occasions not to follow training, policy and guidance regarding completion of paperwork and assessment of patients which led to medication errors and patients not receiving the care needed. In some cases, actual harm was caused to patients by R's negligence. R was repeatedly absent from the workplace on unauthorised breaks, did not complete training when required, and refused to assist colleagues when asked, which put patients at risk by there by physically leaving the ward short of staff and depriving them of a skilled, competent and willing nurse. R's failures also put more pressure on colleagues and the resources of the hospitals/homes concerned.

Leaving aside the issue of dishonesty, R's conduct would demonstrate exceedingly poor decision making, a severe lack of judgment, an inability to work safely despite intensive support and supervision, an absence of initiative and a deficit in thinking skills, contrary of what is expected and required of a registered nurse, which places patients at a real risk of significant harm. This could easily, and did, put colleagues at risk when providing care to patients, due to R being unable and unwilling to conduct and record basic nursing tasks appropriately.

It is further submitted that R's behaviour fell so far short of what was expected of her that it could realistically result in patients, their families and the wider public distrusting nurses, and to their detriment avoiding or refusing care from registered professionals.

In terms of charges 17 & 18, R not only continuously displayed poor clinical practice without concern, but actively encouraged another professional to do the same, by covering up an error, fostering a culture of deception as opposed to one of openness. At charges 53- 55, R then dishonestly made representations to colleagues as to her lack of experience, in order to justify her misconduct. R then maintained this deception by making similar statements in her reflective piece (p5 R's response bundle). The risk to patients under R's

care has already been addressed, however there is an added risk due to the dishonesty present. The dishonesty in this case increases the risk posed by R to patients as she is liable to disguise or hide her acts or omissions, which could result in a real risk to patient health and wellbeing, as demonstrated in the present case.

Dishonest actions can have an impact on, or create issues for fellow members of staff; placing them at risk of harm too, as dishonesty means that information coming from R cannot be relied upon, impacting patients.

Risk of repetition and current impairment

It is submitted that there is a high risk of repetition in this case. It is especially concerning that despite intensive supervision over a lengthy period, support measures put in place by multiple workplaces, and the imposition of an ICOPO R's poor clinical practice continued. It is submitted this is a pattern of behaviour which suggests an attitudinal issue which is difficult to remediate, if remediable at all.

It is submitted that in her written pieces past and present, R has demonstrated limited insight. In her investigation interview minutes with Spire Norwich Hospital (TG2), and her written pieces provided to NursePlus (JC7-JC11), R appears to make excuses or place blame at the door of others without genuinely accepting and comprehending why her own practice was deficient and her behaviour unacceptable. These concerns were raised by the witness SP throughout her involvement with R. Later, in R's disciplinary meeting minutes at Spire (SP2) dated 26th April 2019, R expresses not understanding the need for support and supervision put in place by the employer, but does appear to accept responsibility for her actions, stating that she found being supervised difficult and that there were factors in her personal life going on in the background. R states she does not wish to return to nursing as she knows the concerns will "happen again" (p238). However, following this, R returned to nursing and her poor performance and attitudinal issues persisted in 2020 at Two Acres Care Home, including dishonesty. Following the incidents at Two Acres, R wrote a reflective piece (p5 R's response bundle) in which R again

sought to blame others and excuse her behaviour, repeating similar statements to those found to be dishonest in charge 55. This was followed by a more apologetic reflective piece in November 2020, which demonstrates limited insight (p11 R's response bundle), where R states she seeks to return to nursing.

In her more recent communications with the NMC (R's response bundle p15 & 16, PIA bundle p2, on table email), R states again she will not return to nursing due to the risk posed (p16 response bundle, p2 PIA bundle), put is also ambivalent about this, her position changing in the space of a few weeks (p15). R appears to accept the substance of the charges against her, describing her performance as "disgusting" and citing some personal issues as a contributing factor, which indicates some insight, however given R's previous similar purported acceptances at SP2, the NMC would say that R's response to the concerns appears to be cyclical in nature, a seeming acceptance being followed in the past by repeated behaviour and subsequent lack of insight which presents an ongoing risk. It is unclear as to whether R will again change her mind, as she has done several times in the past, about a return to nursing, which would put the public at high risk.

The panel may think that without remediation there remains a real risk to patient safety and of repetition, in particular in a dishonesty case, therefore the risk to patient safety would be clear and ongoing. However, the panel may also take the view that owing to any change in circumstances for R, the situation is different and is either remediable or remedied. This is however, not the NMC's position, the conduct being serious, and dishonesty being is extremely difficult to remedy particularly where there is lack of insight or remediation.

It is a matter for the panel as to whether they feel sufficient insight has been demonstrated and sufficient steps taken to eliminate any risk.

<u>Public interest grounds</u>

In addition, the panel may think that there is public interest in a finding of impairment, in particular where patients have been placed at risk of harm. The

panel are invited to conclude that, were a member of the public fully informed of the facts, and aware that the registrant were allowed to practice unrestricted, their trust and confidence in the profession, the regulator and the registrant would be undermined.

It is submitted that, where R put patients at serious risk of harm, coupled with the dishonesty present, this case would be considered very concerning to an informed observer who would be disturbed to discover that R was permitted to practice without restriction.

The NMC submits that whilst the other submissions on patient and public safety still stand, impairment may be found in any event in this case, owing to the strong public interest arising out the facts of this case.

More specifically, impairment can be found in order to maintain public trust and confidence in the profession, and to fulfil one of the panel's duties of declaring and upholding proper standards of professional conduct. If the panel are of the view that a finding of impairment is in the public interest in order for them to fulfil this duty then they ought to find impairment on this ground.

<u>Code of conduct – Core Duties</u>
It is submitted that owing to all of the above, R is in breach of the following duties taken from the NMC Code of Conduct:

> ***Core Duty 1 - Treat people as individuals and uphold their dignity***
> *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*

Core Duty 2 - Listen to people and respond to their preferences and concerns

2.1 work in partnership with people to make sure you deliver care effectively

2.5 respect, support and document a person's right to accept or refuse care and treatment

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

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

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

Core Duty 4 - Act in the best interests of people at all times

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

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

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

Core Duty 6 *-* ***Always practise in line with the best available evidence***

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

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

Core Duty 8 - Work co-operatively

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

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

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

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

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

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

Core Duty 10 - Keep clear and accurate records relevant to your practice

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

10.6 collect, treat and store all data and research findings appropriately

Core Duty 13 - Recognise and work within the limits of your competence

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

13.2 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

13.5 complete the necessary training before carrying out a new role

Core Duty 14 - Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

Core Duty 15 - Always offer help if an emergency arises in your practice setting or anywhere else

15.1 only act in an emergency within the limits of your knowledge and competence

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

15.3 take account of your own safety, the safety of others and the availability of other options for providing care

Core Duty 16 - Act without delay if you believe that there is a risk to patient safety or public protection

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

Core Duty 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

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

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

18.4 take all steps to keep medicines stored securely

Core Duty 19 - Be aware of, and reduce as far as possible, any potential for harm associated with your practice

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public1

20 Uphold the reputation of your profession at all times

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

Core Duty 22 - Fulfil all registration requirements

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

It is submitted that R's actions were in breach of the above parts of the NMC Code.

It is submitted that those breaches amount to misconduct, in that they fell short of what was proper in the circumstances.

It is submitted that this misconduct is sufficiently serious, pursuant to the case law and NMC guidance on seriousness.

The panel are invited to consider the case law, NMC guidance (in particular relating to dishonesty) and all the circumstances; balancing fairness between the parties and having regard in particular for the impact of any findings on R, with proportionality in mind.

The NMC submit that it is a matter for the panel as to whether there remains a real risk of repetition, a risk of harm to patients or public safety, or whether there is a public interest basis for finding impairment. The panel may think that by reason of R's misconduct, there remains a risk of repetition and of a real risk of harm to patient and public safety, and/or that there is a public interest reason to find impairment.

It is the NMC's submission that all the above grounds apply, and the panel are therefore invited to find misconduct and that R is currently impaired by reason of that misconduct.'

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* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Holton v GMC* (2006), EWHC 2960 and *Calhaem v GMC* (2007), EWHC 2606.

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 Miss Aird's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Aird's actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

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

2.1 Work in partnership with people to make sure you deliver care effectively

2.5 Respect, support and document a person's right to accept or refuse care and treatment.'

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

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

3.3 Act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it.'

'4 Act in the best interests of people at all times

4.1 Balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

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

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

6.2 Maintain the knowledge and skills you need for safe and effective practice.'

'8 Work co-operatively

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

8.2 Maintain effective communication with colleagues

8.3 Keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 Work with colleagues to evaluate the quality of your work and that of the team

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

9.2 Gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

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

'10 Keep clear and accurate records relevant to your practice

10.1 Complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 Complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.'

'13 Recognise and work within the limits of your competence

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

13.2 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

13.5 Complete the necessary training before carrying out a new role.'

'14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1 Act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 Explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 Document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

‘16 Act without delay if you believe that there is a risk to patient safety or public protection

16.1 Raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices.

16.2 Raise your concerns immediately if you are being asked to practise beyond your role, experience and training.

16.3 Tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can.’

‘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

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

18.2 Keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

18.4 Take all steps to keep medicines stored securely.'

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

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

19.2 Take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

19.3 Keep to and promote recommended practice in relation to controlling and preventing infection

19.4 Take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.'

20 Uphold the reputation of your profession at all times

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

20.2 Act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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.'

'22 Fulfil all registration requirements

22.3 Keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it was of the view that due to the nature of the charges and several issues repeated over a period of time, Miss Aird's actions amounted to misconduct.

In reaching its decision, having considered, and heard all the evidence before it, the panel determined that there is a wide pattern spread across Miss Aird's clinical practice, such as administering medications and treatment of patients, which are basic fundamental skills expected of a nurse. It was of the view that based on the nature of the charges including positive acts and omissions which fell short of expected standards and the issue of dishonesty, there was a potential serious risk of harm to patients.

The panel determined that this amounted to sufficiently serious misconduct in the exercise of her professional practice to be described as misconduct going to her fitness to practise. The panel also found that Miss Aird's conduct would undermine public confidence in the nursing profession and be regarded as deplorable by fellow practitioners.

The panel found that Miss Aird's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, and/or lack of competence, Miss Aird's 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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones.

To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *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) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel finds that patients were put at risk and were on some occasions were caused physical harm as a result of Miss Aird's misconduct. Miss Aird's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered Miss Aird's two Reflective Statements and a handwritten statement where she made admissions and explained her willingness to strengthen her practice, and the training that she has undertaken. However, the panel determined that there was a pattern of Miss Aird demonstrating a degree of insight and then going onto further demonstrating a similar misconduct. This showed lack of insight in relation to how her actions put the patients at risk of harm, the impact on her colleagues and the seriousness of her misconduct. The panel also determined that Miss Aird has not demonstrated an understanding of why what she did was wrong and how this negatively impacted on the reputation of the nursing profession and what she would do differently in similar circumstances in the future.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Miss Aird has taken steps to strengthen her practice. The panel took into account the relevant training that she has undertaken and reflective piece written by Miss Aird dated 24 November 2020 addressing the issues concerned and her realisation to the mistakes that she made.

However, the panel is of the view that there is a risk of repetition based on Miss Aird's lack of insight and absence of evidence in relation to strengthening her practice. In addition, the fact that there is also an element of dishonesty, causes difficulty in remediating this issue considering as it is an attitudinal concern. The panel also acknowledged there is a pattern of behaviour spread across all of Miss Aird's work areas over a prolonged period of time, which also fully justified a finding of fitness to

practise being impaired by lack of competence. The panel further decided that the attitudinal issues would be difficult to remediate. 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; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because a fully informed member of the public would be concerned if they knew that Miss Aird with these charges would be allowed to practice without restriction.

Additionally, 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 Miss Aird's fitness to practise impaired on the grounds of public interest.

However, in relation to the updated NMC guidance as to whether Miss Aird can '*practice kindly, safely and professionally',* the panel determined that it is highly unlikely for Miss Aird to practice safely and professionally.

Having regard to all of the above, the panel was satisfied that Miss Aird's fitness to practise is currently impaired.

Sanction

Ms Chapman provided written submissions to the panel regarding sanction as follows:

> *'The panel have now found there was misconduct and impairment, and reached the sanction stage.*

The NMC submitted that there is current and ongoing risk to patient and public safety if the Registrant ("R") is allowed to practice unrestricted, as her fitness to practice is impaired by her misconduct, and that there was a public interest ground for impairment by virtue of that misconduct

The panel have found dishonesty present in part of the charges found proved, as articulated previously in these proceedings and outlined in the written determination.

The NMC submit that the overarching objective of the panel is public protection, which is one of the grounds on which impairment was found, in addition to the public interest. In light of that, it is submitted that the appropriate sanction for these charges, is a Strike Off Order, and no lesser sanction will suffice.

<u>NMC guidance</u>

When addressing the appropriate sanction, the panel will be assisted by the NMC guidance on sanctions. It is submitted on behalf of the NMC that the following, from the NMC guidance titled 'Factors to consider before deciding on sanctions' should be taken into account:

i. *PROPORTIONALITY*

Finding a fair balance between R's rights, and the overarching objective of public protection. The guidance states that panels should start by considering the least restrictive sanction, and then progress to the next more restrictive accordingly until such sanction is found that imposes the minimal restrictions on R whilst protecting the public in respect of the regulatory concern that is found to underpin the unfitness to practice.

ii. *AGGRAVATING FEATURES*

Any features that may make the case more serious. For example, if a nurse has put a patient at risk of harm, the case is more serious, even

if that harm did not in fact occur. The guidance goes on to give non-exhaustive examples of some features that may be aggravating:

- *any previous regulatory or disciplinary findings*
- *abuse of a position of trust*
- *lack of insight into failings*
- *a pattern of misconduct over a period of time*
- *conduct which put patients at risk of suffering harm.*

These and other aggravating features would point to a more restrictive sanction.

iii. MITIGATING FEATURES

Any features that suggest it is less serious, in other words, the opposite of the aggravating features. These features would point towards a less restrictive sanction.

The guidance states that Mitigation falls within three categories:

- *Evidence of the nurse, midwife or nursing associate's insight and understanding of the problem, and their attempts to address it. This may include early admission of the facts, apologies to anyone affected, any efforts to prevent similar things happening again, or any efforts to put problems right.*

- *Evidence that the nurse, midwife or nursing associate has followed the principles of good practice. This may include them showing they have kept up to date with their area of practice.*

- *Personal mitigation, such as periods of stress or illness, personal and financial hardship, level of experience at the time in question, and the level of support in the workplace.*

The NMC guidance states that the purpose of a sanction is not to punish R, but to protect the public and address the risk. With that in mind, the guidance is clear that personal mitigation is usually less relevant than it would be when punishing offenders in the criminal justice system.

Regarding harm, the guidance reiterates that patient harm is taken extremely seriously, that putting patients at risk of harm makes the failings more serious. If the nurse put patients or members of the public at a real risk of suffering harm, the patient suffering no actual harm, or the reasons for the patient not suffering that actual harm, is "generally not a good mitigating factor".

The panel will also have regard to any previous interim or substantive orders and sanctions against R. The registrant was made subject to an ICOPO on 20th June 2019. Despite this, as per the panel's findings, the concerns continued during R's practice.

Sanctions for serious cases

Panel is referred to NMC's guidance on 'Considering sanctions for serious cases', which says, "Sometimes, the nurse, midwife or nursing associate's conduct may be so serious that it is fundamentally incompatible with continuing to be a registered professional".

The law

A sanction can also be used to deter others, other than in relation to the primary issue of public safety. In this instance, reasoning is particular important to showing proportionality.

Brennan & the Health Professions Council [2011] EWHC 41 (Admin)

At paragraph 47 of Brennan it states that:

> *"Where the purpose of sanction is to deal with issues other than the*

primary one of maintaining public safety, and is instead to provide deterrence to others, to maintain confidence in the profession's reputation and standards and in its regulatory process, the reasoning is particularly important in showing that the sanction is proportionate to the misconduct and for the individual. This important issue is dealt with by the mere statement of a conclusion. What was required was consideration of how the individual had responded, the sincerity and effectiveness of that response, the reality of repetition in view of his insight, if accepted, into how the practice of the profession related to his obligations to his employer in professional sport, the punishment inflicted by the sport's regulatory body, and the effect which various sanctions would have on the legitimate objectives of sanction for unfitness to practice. That did not occur. I was troubled that the reasoning included the comment that the sanction had been arrived at in part by the process of elimination given the weight that that puts on the starting point in the chain of reasoning. That reasoning, though not illegitimate, does require a very clear examination of whether the end result is proportionate, or whether the result would have been different if strike off had been considered first. This is especially important since there is no sanction available between a one year suspension and strike off. Strike off should be seen as ending the professional livelihood of the registrant as a physiotherapist, in this case, the only profession for which he is trained, and in which he has worked for many years. That does call for careful consideration of the evidence and reasoning, in what was an unusual case.

Daraghmeh v General Medical Council [2011] EWHC 2080 (Admin)

The above case concerns Conditions of Practice Orders and proportionality. In particular with having regard to the impact that any conditions have on the Registrant, including whether those conditions make it impossible for the Registrant to practise, essentially amounting to a suspension in all but name.

The panel should therefore not impose a conditions of practice order that would be tantamount to a suspension order by back door. Any conditions imposed need to be workable and not impossible to comply with.

The present case

It is submitted that in the present case the following aggravating features apply:

- *The conduct put patients at real risk of suffering harm*
- *The conduct caused some patients actual harm*
- *Repeated incidents in a number of workplaces*
- *Interim Condition of Practice Order in place to address similar concerns at the time of some of the charges found proved*
- *Lack of insight or remediation*
- *Evidence of a deep-seated attitudinal issue*

It is submitted that in the present case, the following mitigating features apply:

- *A general acceptance that the performance was poor in recent communications with the NMC*

It is submitted that these factors are not exhaustive, and the panel may find additional aggravating and mitigating features to which they will attach the appropriate weight accordingly.

Available sanctions

No action

It is submitted that this is not suitable for taking no action as the conduct is serious and presents a risk to the public.

Caution Order

It is submitted that in the present case, a caution order would not be sufficient to reflect the seriousness of the case or protect the public.

Conditions of Practice Order

It is submitted that a Conditions of Practice Order would not be appropriate to address the lack of insight and dishonesty, and therefore would not protect the public. There are serious clinical concerns involved in this case which have not been resolved despite several years of intensive supervision, and despite the R being subject to an ICOPO. The Registrant has shown little insight. There is an attitudinal issue with honesty and integrity as well as an unwillingness to learn from mistakes and colleagues; there would therefore be no workable conditions that would mitigate against the real risk of repetition demonstrated. The conduct has the potential to seriously undermine public trust in the profession, especially given the failure of the prior ICOPO to adequately address the risk. For those reasons a conditions of practice order is not suitable.

Suspension Order

The NMC's guidance on suspension orders states that this would be appropriate where there is:

- *no evidence of harmful deep-seated personality or attitudinal problems*
- *the Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour*

Although a suspension order would protect patients against immediate harm, it is submitted that it is not the appropriate sanction because it would not address the underlying issues in this case - R's honesty and integrity, her unwillingness to learn from mistakes/colleagues, and lack of insight and remediation.

In all the circumstances of this case NMC submits that a temporary removal from the register is insufficient to address the level of risk and public interest

factors. The registrant's attitude and lack of insight demonstrates conduct incompatible with ongoing registration.

Strike Off

It is submitted that in light of the serious clinical failings and risk to the public, the underlying attitudinal issues coupled with a lack of insight, the only appropriate sanction to achieve the overarching objective of patient safety, and public protection, is a strike off order.

The following are questions are featured in the NMC's guidance when considering if a striking off order is suitable:

- *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*

  The NMC say yes

- *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*

  The NMC say no.

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

  The NMC say yes.

It is submitted that the strike off order is the only order capable of preserving public confidence in the profession and the NMC as a regulator, protecting the public and providing a deterrence for others.

Conclusion

It is submitted, in particular in light of the panel's findings as to the R's attitudinal issues and dishonesty/lack of integrity, that the Registrant's conduct is incompatible with continued registration.

Consequently, it is submitted that owing to the nature of dishonesty in the R's behaviour, the aggravating features, and the lack of insight/remediation, a strike off order is the only appropriate sanction to protect the public, and for the protection of the reputation of the profession and NMC as a regulator.

The panel are therefore invited to make a strike-off order.'

Decisions and reasons on sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Aird off the register. The effect of this order is that the NMC register will show that Miss Aird has been struck-off the register.

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

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

The panel took into account the following aggravating features:

- Lack of insight into failings;

- A pattern of misconduct over a significant period of time spread over various disciplines of her practice and occurred at several different places of employment;
- Conduct which put patients at risk of suffering harm, and did cause some patients' harm;
- Deep seated attitudinal concerns;
- The panel also noted that Miss Aird had been subject to an interim conditions of practice order (ICOPO) to address similar concerns at the time of some of the charges found proven in this case.

The panel found no mitigating circumstances, other than a general acceptance by Miss Aird that her performance was poor in recent communications with the NMC.

[PRIVATE]. However, there was insufficient detail and/or evidence to make an informed decision in this regard.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Aird'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 Miss Aird'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 the case. The panel decided that it would be neither proportionate nor serve the public protection concerns or be in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Aird's registration would be a sufficient and appropriate response. The panel is of the view

that there are no practical or workable conditions that could be formulated, given the nature of the charges found proven in this case. Due to the attitudinal issues, the misconduct identified in this case was not something that can be addressed through retraining. The panel determined that Miss Aird had limited potential and an unwillingness to respond positively to training. Despite the ICOPO referenced above, Miss Aird had failed to fully address failings in her practice. Furthermore, the panel concluded that the placing of conditions on Miss Aird's registration would not adequately address the seriousness of this case and would not protect the public and serve the 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:

- *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.*
- *No evidence of harmful deep-seated attitudinal problems.*
- *No evidence of repetition of behaviour since the incidents.*
- *The Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour.*

The panel considered that none of the above points apply in this case.

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 serious breach of the fundamental tenets of the profession evidenced by Miss Aird's actions is fundamentally incompatible with Miss Aird remaining on the register.

In this particular case, the panel determined that a suspension order would be insufficient to protect patients and the public interest and would not be a sufficiently appropriate or proportionate sanction.

Finally, in looking 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 noted that whilst it found Miss Aird's actions in charges 53 and 54 to be dishonest, it did not consider her dishonesty to be at the top end of the dishonesty spectrum. Nevertheless, the panel were satisfied that these charges as found proven were serious and dishonesty can undermine the trust which the public place in the nursing profession.

Miss Aird's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Aird's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel acknowledged the reference provided by Miss Aird's colleague dated 1 June 2020, which states that she had worked with Miss Aird for 7 months and was described as '*hardworking, helpful and considerate carer'*. The panel also acknowledged another positive reference provided by her Deputy Manager dated 20 November 2020 but noted that this is not a current reference and the Deputy Manager only worked with Miss Aird on two shifts. The panel determined that it is not clear whether these colleagues were aware of the nature of the allegations concerned. The panel also considered Miss Aird's Reflective Statements one of which is undated and the other dated 24 November 2020. However, the panel

determined that the Reflective Statements do not demonstrate the required level of insight or address Miss Aird's deep seated attitudinal issues.

Balancing all of these factors, and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Aird's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was 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 in Miss Aird'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 Ms Chapman and she submitted that an interim order would be appropriate for public protection and required on the ground of public interest.

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 as Miss Aird has shown a lack of insight due to the repetition of her actions, which is an ongoing risk to patients, to members of the public and the reputation of the nursing profession. Therefore, the panel determined that a suspension order is appropriate.

This will be confirmed to Miss Aird in writing.

That concludes this determination.