Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Friday, 17 March 2023 – Thursday 23 March 2023
Monday, 27 March 2023 – Wednesday 5 April 2023

Virtual Hearing

Name of Registrant:	Kay Beaumont
NMC PIN	18B0472E
Part(s) of the register:	Nursing, Sub part 1 RNA, Registered Nurse – Adult (19 July 2018)
Relevant Location:	Cheshire
Type of case:	Lack of competence
Panel members:	Nicola Jackson (Chair, lay member) Pamela Campbell (Registrant member) Alison Hayle (Lay member)
Legal Assessor:	John Bromley-Davenport KC
Hearings Coordinator:	Opeyemi Lawal (17 March – 29 March, 3 April – 6 April 2023) Max Buadi (30 March – 31 March 2023)
Nursing and Midwifery Council:	Represented by Claire Stevenson, Case Presenter
Miss Beaumont:	Not present and unrepresented
Facts proved:	Charges 1a, 1b, 2, 3a(i-iii), 3b, 3d(i-iii), 3e(i-ii), 3f, 3g(i), 3h(i-ii), 3i, 3j(i-ii), 3k(i), 3k(iii), 3k(v), 3m (i-ii), 3n, 4a(i-iv), 4b(i-iii), 4c(i-iii), 4d(i-ii), 4e(i), 4e (iii-vii), 4f(i-ii), 4f(iv), 4f(v-vii), 4f(viii), 4f(ix), 4g(i), 4g(iii), 4h(i-ii), 4i(i), 4j, 4k, 4l(i-v), 4m(i-ii) 4n, 4o (i(a-c)-iv), 4p (ii), 4p (iv), 4p (vii), 4p (ix-xii)

Facts not proved:	Charges 3c, 3g(ii), 3j(iii), 3k(ii), 3k(iv), 3l, 3o, 4b(iv),4e (ii), 4f(iii), 4g(ii), 4i(ii) 4p (i), 4p (iii), 4p (v), 4p (vi), 4p (viii),
Fitness to practise:	Impaired
Sanction:	Suspension order (12 months)
Interim order:	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 Beaumont was not in attendance and that the Notice of Hearing letter had been sent to Miss Beaumont's registered email address by secure email on 15 February 2023.

Ms Stevenson, 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 Beaumont 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 Beaumont 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 Beaumont

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

Ms Stevenson submitted that there had been no engagement by Miss Beaumont with the NMC in relation to the substantive proceedings and, as a consequence, there was

no reason to believe that an adjournment would secure her attendance on some future occasion.

However, Ms Stevenson referred the panel to the email from Miss Beaumont, which referred to previous review hearing dated 7 June 2022, stating:

> *'I am NOT interested in ever being a nurse again. My experience was awful. I am through with nursing. I have no interest in being involved with any review hearings.'*

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Miss Beaumont. In reaching this decision, the panel has considered the submissions of Miss Beaumont and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* 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 Beaumont;
- Miss Beaumont has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Three witnesses are due to attend to give live evidence;
- 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 Beaumont in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC 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 Beaumont'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 Beaumont. The panel will draw no adverse inference from Miss Beaumont's absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Stevenson, on behalf of the NMC, to amend the wording of charges 3k(i), 2, 4d(i), 4d(ii), 4e(ii), 4e(iii), 4k, 4l(iv).

The proposed amendment was to correct typographical and grammatical errors. It was submitted by Ms Stevenson that the proposed amendment would provide clarity and more accurately reflect the evidence.

"That you, a registered nurse:

…

3. While subject to Performance Improvement Plan and/or while under supervision:

…

k. On 15 May failed to:

ii. Apply a topical medication before a ~~p~~Patient**'s** legs were washed;

…

~~2)~~ **4.** While subject to Capability Plan (Informal) and/or while under supervision:

…

d. On 15 June 2020:

i. ~~Could~~ Demonstrated poor communication skills ~~patient~~ in relation to washing a patient;

ii. Caused a cannula to be removed from a patient**'**s arm

e. On 15 June 2020 failed to:

ii. Record the reason for not administering ~~Frusemide~~ **Bisoprolol**;

iii. Dispose of ~~Frusemide~~ **Bisoprolol** correctly and /or in a timely manner.

….

k. On 15 July 2020 failed to ~~E~~**e**scalate to a doctor a patient with a CIWA score of 10 to, in a timely manner.

l. On 15 July 2020 in relation to a patient with a NEWS score of 4 failed to:

iv. Set up an Intravenous **in**fusion for the patient;~~.~~

….

And in light of the above, your fitness to practise is impaired by reason of your lack of competence."

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 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 Beaumont and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Details of charges as amended

That you, between 6 April 2019 and 7 August 2020 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that:

1) On 7 April 2019, while under supervision did not administer an Intravenous infusion correctly, namely clarithromycin, in that you:

a) Diluted the clarithromycin with 100mls of normal saline;
b) Set the clarithromycin infusion to run over 30 minutes.

2) On 7 April 2019, while under supervision, failed to administer the correct dose of medication, namely tramadol to one or more patients.

3) While subject to Performance Improvement Plan and/or while under supervision:

a) On 12 November 2019, failed to:

    i) Escalate a patient's condition to a doctor in a timely manner;
    ii) Carry out hourly observations as required and/or advise;
    iii) Take any or any adequate action when the patient's condition deteriorated.

b) On 20 December 2019, did not follow the advice of a senior colleague relating to the preparation of intravenous medication, namely Teicoplanin.

c) On 6 January 2020, failed to administer oxygen correctly to an unknown patient, namely by providing the incorrect amount/supply of oxygen.

d) On 7 January 2020 failed to:
    i) Assess a NEWS score correctly;
    ii) Observe that a patient was unresponsive;
    iii) Take any or any adequate action when a patient's condition deteriorated.

e) On 9 January 2020 in relation to glucose monitoring failed to:

    i) Recognise that urine ketones could be checked;
    ii) Locate the guidelines relating to blood sugar levels on patient charts.

f) On 9 January 2020 failed to document the Intravenous fluids on a fluid balance chart.

g) On 9 January 2020 failed to ensure:
    i) A patient, received 1:1 care/observations.
    ii) A diabetic patient, received medication, namely insulin in a timely manner.

h) On 17 January 2020 failed to:

    i) Carry out observations on one or more patients;
    ii) Prepare medication correctly, namely the diluting of 1g of intravenous Amoxicillin with water.

i) On or around 21 April 2020 administered the incorrect dose of intravenous paracetamol infusion, namely a 750 mg infusion.

j) On the 14 May 2020 failed to:
    i) Sign for a Nicotine patch that had been administered;
    ii) Apply 50:50 crème which had been signed as administered;
    iii) Administer a dose of 30 mg of Chlordiazepoxide.

k) On 15 May failed to:

i) Administer medications in a timely manner;
ii) Apply a topical medication before a patient's legs were washed;
iii) Set up an intravenous fluid in a timely manner;
iv) Give a PRN nebuliser at the correct time/interval;
v) Record the correct code on a Wardex relating to "Ted Stockings";

l) On one or more occasions gave medications in advance of the time when they were due to be administered.

m) On 28 May 2020 failed to administer the correct dose of:
i) Oxygen to a patient, namely 0.5 litre.
ii) Medication, namely 25 mg of Sildenafil to a patient..

n) On 28 May 2020 failed to recognise the route of administration of a PRN medication was subcutaneous.

o) On 2 June 2020 did not follow instructions from a senior colleague relating to moving/relocating patients.

4) While subject to Capability Plan (Informal) and/or while under supervision:

a) On 10 June 2020:

i) Could not explain what Champix (Varenicline) was used for;
ii) In relation to Acyclovir, failed to check a patient's details;
iii) Failed to flush an intravenous line correctly;
iv) Failed to complete the body mass index (BMI) for a patient.

b) On 11 June 2020 failed to:

i) Observe a patient was “Nil by mouth”;
ii) Failed to recognise a patient was to receive Ipratropium;
iii) Failed to recognise an unknown medication and/or check its use before administering to a patient;
iv) Failed to escalate a patient with a NEWS score of 5, in a timely manner.

c) On 12 June:

i) Failed to take any or any adequate action regarding a patient suffering from chest pains;
ii) Did not complete the medication round in a timely manner.
iii) On one or more occasions failed to check the identity of a patient, before administering medication.

d) On 15 June 2020:

i) Demonstrated poor communication skills in relation to washing a patient;
ii) Caused a cannula to be removed from a patient’s arm.

e) On 15 June 2020 failed to:

i) Recognise that the medication, namely Frusemide, should not be administered to a patient;
ii) Record the reason for not administering Bisoprolol;
iii) Dispose of Bisoprololcorrectly and /or in a timely manner.
iv) Complete documents for a new admission;
v) Disconnect a patient from an insulin pump;
vi) Prepare a medication correctly, namely intravenous Ondansetron;
vii) Administer a topical 50:50 cream at the correct time.

f) On 16 June 2020 failed to:

i) Carry out morning observations and/or care rounds on one or more patients;
ii) Complete a new care plan for a new catheter;
iii) Sign the oxygen scale in a patient's Wardex;
iv) Carry out any or any adequate checks on a patient who was later found deceased;
v) Carry out a blood sugar check in a timely manner, for one or more patients;
vi) Administer insulin in a timely manner, namely before breakfast;
vii) Administer codeine, at the correct time, and/or, not one or more hours in advance of the due time;
viii) Administer a medication at the correct time and/or day;
ix) Remove the correct medication patch from a patient, namely a Glyceryl Trinitrate (GTN) patch.

g) On 17 June 2020 failed to:

i) Recognise that a dose of medication was no longer prescribed, namely Amlodipine;
ii) Administer a medication namely codeine, at the correct time;
iii) To store a medication correctly, namely a liquid antibiotic.

h) On 23 June 2020, failed to:

i) Record observations in official records;
ii) Complete records accurately and/or in a timely manner.

i) On 15 July 2020 in relation to a patient with a haemoglobin level of 61 failed to handover information:

i) To another colleague relating to the patient's condition;
ii) Relating to the patient receiving 2 units of blood.

j) On 15 July 2020 did not recognise that the dose of antibiotics prescribed for a patient was low.

k) On 15 July 2020 failed to escalate to a doctor a patient with a CIWA score of 10 to, in a timely manner.

l) On 15 July 2020 in relation to a patient with a NEWS score of 4 failed to:
    i) Escalate to a doctor in a timely manner;
    ii) Provide a doctor with the patient's history relating to tachycardia and/or low blood pressure;
    iii) Administer medication, namely Digoxin in a timely manner;
    iv) Set up an Intravenous infusion for the patient;
    v) Ensure a Telemetry box for the patient was able to measure/transmit.

m) On 21 July 2020 in relation to a new admission at 08:05 hrs failed to:

    i. Complete the admission of the patient;
    ii. Ensure the patient received intravenous fluids in a timely manner.

n) On one or more occasions failed to use 3 patient identifiers, namely name, date of birth, and hospital/NHS number on each page, namely on:

    i) 28 July 2020;
    ii) 30 July 2020.

o) On 5 August 2020:
    i) Gave inaccurate patient information during a handover relating to;
    a) NEWS scores;
    b) Intravenous Antibiotics (IVAB);
    c) Patients medication.
    ii) Did not recognise how to improve the low blood pressure of a patient, namely by altering the patient's position;

iii) Failed to complete a Waterlows score (Pressure Ulcer Risk assessment chart);
iv) Did not identify a patient by their ID band before administering Codeine.

p) On 6 August 2020 failed to:

i) Check the blood sugar levels for one or more patients;
ii) Administer anticipatory medication to a patient;
iii) Indicate that a medical record was made retrospectively:
iv) Indicate that a Waterlows score for 5 August 2020 was completed retrospectively;
v) Carry out Visual Inspection of Phlebitis (VIP);
vi) Record observations in (VIP) charts;
vii) To have a stethoscope that could be used whilst on duty;
viii) Administer medication in a timely manner;
ix) Inform a doctor of the complete clinical details of a patient;
x) Complete step B of the ABCDE assessment of a the patient;
xi) Take adequate action relating to the patient's deteriorating condition;
xii) Correctly programme equipment for Intravenous medication.

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

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

At the outset of the hearing, Ms Stevenson made a request that this case be held partly in private on the basis that proper exploration of Miss Beaumont's case involves reference to her health. 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 go into private session as and when references are made to Miss Beaumont's health.

Background

Miss Beaumont was referred to the NMC on 25 January 2021, by Ms 1, Ward Manager, Leighton Hospital ('the Hospital'), Mid Cheshire Hospitals NHS Foundation Trust ('the Trust').

At the time of the alleged concerns, Miss Beaumont was working at the Hospital as a Band 5 staff nurse on Ward 2 ('the Ward').

Miss Beaumont commenced employment on the Ward in August 2018 as a newly qualified nurse.

The Ward was a short stay ward treating acutely unwell patients and was very fast paced.

[PRIVATE]

The Trust raised concerns about multiple incidents that were alleged to have taken place between April 2019 and August 2020. The concerns relate to:

1. Failure to maintain the knowledge and skills needed for safe and effective practice;
2. Responding and listening to people's preferences and concerns;
3. Safe medication administration;
4. Completing records accurately without falsification;
5. Effective communication;
6. Ability to identify, observe and assess signs of normal or worsening physical mental health in patients;
7. Making timely referrals to another practitioner when required;

8. Promoting practice in relation to control and prevention of infection.

The Trust implemented a Personal Improvement Plan in May 2019 and a Capability Plan in June 2020, but the concerns continued. Miss Beaumont thereafter resigned from the Trust in January 2021.

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 Stevenson on behalf of the NMC.

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

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

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

- Ms 1: Manager of Ward 2 at Mid Cheshire Hospitals NHS Foundation Trust.
- Ms 2: Band 6 Ward Sister
- Ms 3: Sister on Ward 2

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The panel had access to and considered witness statements, oral evidence and exhibits comprising, amongst other things, emails from supervisors who had been overseeing Miss Beaumont's work. These emails had been sent to the ward

manager on the same day or within a few days of the alleged incidents occurring. These emails therefore carried particular weight because of their contemporaneous nature meaning that recollection of events had not been affected by the passage of time. The emails contained both positive and negative comments on Miss Beaumont's performance.

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

Charge 1

"On 7 April 2019, while under supervision did not administer an Intravenous infusion correctly, namely clarithromycin, in that you:

a) Diluted the clarithromycin with 100mls of normal saline;
b) Set the clarithromycin infusion to run over 30 minutes."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In an email written by Ms 2 on 9 April 2019, two days after the incident, she wrote:

> *'Noticed that the patient had an IV infusion of Clarithromycin running that was administered by SN Beaumont – the infusion was diluted in the wrong amount of normal saline (100mls – should have been 250mls) and was running over half an hour – should have been an hour.'*

The panel determined that as the email was written two days after the incident, this represents strong contemporaneous evidence.

In Ms 2's witness statement she stated:

‘This was a weekend shift and Kay asked me to take bloods off of a patient and I noticed that the patient had a drip but that the medication had been setup wrong. I stopped the medication and realized that it was the right medication but it had been diluted in too little saline and was only set to be given over 30 minutes. The correct dose would have been twice the saline over one hour.’

The panel noted that there was a second checker but reasoned that this did not absolve Miss Beaumont of her responsibilities.

The panel determined that Ms 2’s oral evidence was consistent with the exhibits and her witness statement.

The panel found this charge proved.

Charge 2)

> “On 7 April 2019, while under supervision, failed to administer the correct dose of medication, namely tramadol to one or more patients.”

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2’s witness statement and oral evidence.

In an email written by Ms 2 on 9 April 2019, two days after the incident, she wrote:

‘When checking controlled drugs noticed that she had not given 2 patients the right amount of the drug – they should have had twice as much she gave them. When I asked her about it she stated that she thought they were 100mg tablet.’

In Ms 2’s witness statement she stated:

'During the shift on 7 April Kay also made a mistake with medication for two other patients where Kay didn't check the dosage of the tablet medication and just gave one pill when this was actually not the proper dosage.

…

When the mistake was pointed out to Kay she stated she didn't really check the dosage amount for each tablet.'

Again, the panel acknowledged that there was a second checker present during this incident.

The panel determined that Ms 2's oral evidence was consistent with the exhibits and her witness statement.

The panel found this charge proved.

Charge 3a(i)

"While subject to Performance Improvement Plan and/or while under supervision:

a) On 12 November 2019, failed to:
    i. Escalate a patient's condition to a doctor in a timely manner;

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

'I told Kay she needed to escalate to the medics on the Ward. Later on in the shift…...Kay had not already escalated the patient to them…'

In her oral evidence Ms 2 explained that it was hospital policy that a patient with a NEWS score of 5 or above should have hourly observations and be escalated to medics. She confirmed that she had advised Miss Beaumont to escalate the patient to the medics, but on their ward round they confirmed that no such escalation had occurred

Ms 2 was clear in her evidence and witness statement that Miss Beaumont had not escalated the patient's condition to the doctor.

The panel noted that Ms 2's exhibits do not directly talk about the incident, but her evidence was not inconsistent.

The panel therefore found this charge proved.

Charge 3a(ii)

> "While subject to Performance Improvement Plan and/or while under supervision:
>
> a) On 12 November 2019, failed to:
>
> ii. Carry out hourly observations as required and/or advise

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'…As I told the medics about the patient, with Kay listening, they said to do hourly observations. Kay said "fine" so I assumed she would be following up on the plan. However, when it was time for the night shift handover I found that Kay had not done hourly observations on the patient.'*

'Kay had not already escalated the patient to them. As I told the medics about the patient, with Kay listening, they said to do hourly observations. Kay said "fine" so I assumed she would be following up on the plan. However, when it was time for the night shift handover I found that Kay had not done hourly observations on the patient.'

The panel determined that Ms 2's oral evidence was consistent with the exhibits and her witness statement.

The panel therefore found this charge proved.

Charge 3a(iii)

"While subject to Performance Improvement Plan and/or while under supervision:

a) On 12 November 2019, failed to:

iii. Take any or any adequate action when the patient's condition deteriorated."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's feedback for Miss Beaumont to Ms 1, she stated:

'…I was very concerned that Kay had not repeated her observations at any point, she did not appear to understand that the patient was dying and did not know what to do when I told her the patent had looked like she had deteriorated.'

In Ms 2's witness statement she stated:

'When I went to check on this patient at this time I could tell that the patient was dying. This is nothing to do with anything Kay did or didn't do as the patient had

been very unwell. However, if observations had been done hourly and correctly we would have noted this sooner and been able to make sure the correct pathway was being followed. When I noticed that the patient was dying I rushed to contact the family and make sure that they could come to be with the patient as well as other standard protocols for when a patient is going to die such as getting a Registrar in. The risk of not doing regular observations for patients like this is that they deteriorate very quickly and we have no way of helping them.'

The panel determined that Ms 2's oral evidence was consistent with the exhibits and her witness statement.

The panel determined that the appropriate action was taken by Ms 2 and not by Miss Beaumont.

The panel found this charge proved.

Charge 3b

"On 20 December 2019, did not follow the advice of a senior colleague relating to the preparation of intravenous medication, namely Teicoplanin."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

'I told Kay to wait for [Ms 3] to come back from her break to do this. I then got busy with other work but noticed that Kay was in the medications room drawing up the IV medication anyway.'

The panel determined that Ms 2's oral evidence was consistent with the exhibits and her witness statement.

The panel considered that this may have been an attempt on Miss Beaumont's behalf to be proactive. However, it was a direct contravention of instruction.

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

Charge 3c

> "On 6 January 2020, failed to administer oxygen correctly to an unknown patient, namely by providing the incorrect amount/supply of oxygen."

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's feedback for Miss Beaumont to Ms 1, she stated:

> *'It was brought to my attention [by a HCA] that the observations had been documented wrong, on one patient Kay had put that the patient was on 0.5 litres of 02 and patient was actually on 3 litres of 02 and dropping her saturation.'*

> *'…it appeared that she had been looking at the oxygen port next to the port that was actually turned on and attached to the patient. The port Kay had been looking at was turned off and not attached to the patient.'*

The panel were clear that Miss Beaumont had made a serious error in confusing which port the oxygen was fed from, and consequently documented the wrong level of oxygen. However, the panel determined that there is no clear evidence of what level of oxygen the patient should have been receiving at that time, and so it cannot be satisfied that Miss Beaumont was providing the wrong amount.

Therefore, on the balance of probabilities, the panel found this charge is not proved.

Charge 3d(i)

"On 7 January 2020 failed to:

i. Assess a NEWS score correctly"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'Also, on this shift Kay again recorded a patient's observation wring [sic]. She had recorded that a patient had a NEWS score of six when it was a nine. This is a very big difference in NEWS score… Kay had noted in her observations that the patient was alert, which was not true. When I asked Kay about this she said that she had just gone off how the patient was the day before. I was shocked by this.'*

In Ms 2's feedback to Ms 1 concerning Miss Beaumont, written three days later, she stated:

> *'Kay once again recorded observations wrong on this day, she scored a patient a NEWS of 6 when in actual fact it was a NEWS of 9 as the patient had been unresponsive.'*

Ms 2's oral evidence confirmed this again.

The panel noted that Miss Beaumont had a duty of care and accurate assessment of patient observations is a fundamental part of nursing practise.

The panel found this charge proved.

Charge 3d(ii)

"On 7 January 2020 failed to:

ii. Observe that a patient was unresponsive"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'The patient's daughter was in and noted that the patient was not responding. When I checked I found that the patient was unresponsive. Kay had noted in her observations that the patient was alert, which was not true. When I asked Kay about this she said that she had just gone off how the patient was the day before. I was shocked by this.'*

The panel noted that Ms 2's oral evidence was consistent with this documentary evidence.

The panel found this charge proved.

Charge 3d(iii)

"On 7 January 2020 failed to:

iii. Take any or any adequate action when a patient's condition deteriorated"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence, in particular the section quoted in charge 3d(ii) above.

From this evidence the panel concluded that, because Miss Beaumont had not recognised that the patient had become unresponsive, she had not taken any of the actions that would be required in this situation when the patient's condition deteriorated.

In oral evidence, Ms 2 told the panel how it was a missed opportunity to ease the end of life for the patient and family that could have had a profound effect.

The panel found this charge proved.

Charge 3e(i)

> "On 9 January 2020 in relation to glucose monitoring failed to:
> iii. Recognise that urine ketones could be checked;"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 3's witness statement she stated:

> *'One concern was where a patients BM (blood glucose monitoring) was high (meaning they had high blood sugar) and I asked Kay what she should do in this situation. It took Kay a while to remember what she should do in this situation and was unaware that she could check urine keytones [sic].'*

In the email dated 9 January 2020, Ms 3 stated:

> *'Kay eventually noted that she need [sic] to check the ketones but didn't know that we (as nurses) could do this or how we would do this.'*

The panel determined that Ms 2's oral evidence was consistent with the exhibits and her witness statement.

The panel noted that Miss Beaumont had a duty to check urine ketones as it is a common requirement for people who have diabetes. Diabetes is a common disease and it is therefore reasonable to expect that a nurse should know about, and check for, ketones.

The panel found this charge proved.

Charge 3e(ii)

> "On 9 January 2020 failed to:
>
> ii. Locate the guidelines relating to blood sugar levels on patient charts."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 3's witness statement she stated:

> *'There are guidelines written on the patient charts that would guide a nurse in what they should do so it should not have been difficult for Kay to know what the next steps were. It took a lot of prompting to get Kay to know what care needed to be given to the patient.'*

In an email written on 9 January 2020 by Ms 3 to Ms 1 she stated,

> *"I had to prompt [Kay] to look at the BM chart to see what else needed doing."*

The panel also took note of evidence that Miss Beaumont continued to question the action relating to the blood glucose level with another nurse.

In oral evidence and documentary evidence the panel were advised that guidelines were clearly displayed on the patient's charts.

Therefore, Ms Beaumont failed to locate the guidelines because she was still debating what to do, and in fact the guidelines were on the patient's chart.
The panel found this charge proved.

Charge 3f

> "On 9 January 2020 failed to document the Intravenous fluids on a fluid balance chart."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 3's witness statement she stated:

> *'Another concern was that Kay was not documenting the IV fluids a patient was getting in their fluid balance chart. It took a lot of prompting to get Kay to remember that she had to do documentation. Issues with documentation were a recurring issue.'*

Also, in the contemporaneous email dated 9 January 2020, Ms 3 also noted:

> *'Not documenting IV fluids in the fluid balance. Kay had put these fluids up herself (with my authorisation) so was aware that they were there and running but hadn't documented them in the fluid balance.'*

Ms 3's oral evidence confirmed what was stated in her witness statement and exhibits.

The panel were of the view that the importance of recording IV fluids on a fluid balance chart was basic nursing knowledge.

Therefore, the panel found this charge proved.

Charge 3g(i)

"On 9 January 2020 failed to ensure:

i. A patient, received 1:1 care/observations"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 3's witness statement she stated:

> *'Another concern during this shift was that Kay was to give 1 to 1 care to a patient who was a high risk for self-harm as well as absconding. Kay had been told this and to make sure she watched the patient (who had self-harmed the night before).'*

Details of this incident were also in the contemporaneous email written on the same day by Ms 3. This clearly stated that Miss Beaumont was asked to provide 1 to 1 care to the patient, meaning she was the nurse directly looking after the patient with no other responsibilities. Despite this the patient wandered off the bay.

During Ms 3's oral evidence she emphasised that the patient's condition and risk of self harm had been made clear to Miss Beaumont during the handover.

The panel noted that the implications of not being vigilant in giving the patient 1 to 1 care were serious and it should have been done effectively.

The panel found this charge proved.

Charge 3g(ii)

"On 9 January 2020 failed to ensure:

ii. A diabetic patient, received medication, namely insulin in a timely manner."

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and her oral evidence.

In the email written, on the same day of this shift, by Ms 3, she made reference to Miss Beaumont not priming the insulin needle correctly and not understanding the need to prioritise giving insulin to patients with diabetes, but she did not state that the insulin had not been given on time.

The panel also noted that there is no evidence to indicate when the insulin was administered and when it was supposed to be administered.

The panel determined that the evidence relating to the charge is not clear and found this charge not proved.

Charge 3h(i)

"On 17 January 2020 failed to:

i. Carry out observations on one or more patients"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and her oral evidence.

In Ms 2's witness statement she stated:

'When I came back Kay said she had finished the observations. I went to check the documentation privately and noticed that Kay had not done observations on the patients in the side rooms all day. I mentioned this to Kay at the night shift handover as Kay would sometimes write her observations on bits of paper and then transfer over. I thought she had maybe just not transferred them. However, Kay said she just hadn't done the observations at all and that she was sorry but she had forgotten. Thankfully these patients were not acutely unwell, if they had been could have been catastrophic…there was no reason that Kay should have forgotten to do these observations'

Ms 2 stated during her oral evidence that carrying out observations is a basic duty of a nurse, and that observations should have been conducted at least 4 to 6 hourly.

The panel determined that it is clear that Miss Beaumont did not carry out the observations as required.

Therefore the panel found this charge proved.

Charge 3h(ii)

"On 17 January 2020 failed to:

ii. Prepare medication correctly, namely the diluting of 1g of intravenous Amoxicillin with water"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and her oral evidence.

In the email written by Ms 2 on the date of the incident she detailed how Miss Beaumont reconstituted IV Amoxicillin incorrectly, using 10mls of water rather than the required 20mls.

The panel found this charge proved.

Charge 3i

> "On or around 21 April 2020 administered the incorrect dose of intravenous paracetamol infusion, namely a 750 mg infusion."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 1's witness statement and her oral evidence.

In Miss 1's witness statement she confirms that Miss Beaumont was supervised by another nurse, who was in charge of coordinating the ward.

Miss Beaumont's supervisor sent an email a few days after the incident stating that Miss Beaumont had given an incorrect dose of IV Paracetamol. The email explains how the infusion had been stopped by another nurse at 500mgs, and then Miss Beaumont had restarted it: *"Kay stated to me that she thought because she was on a normal dose of tinzaparin then she must be on a 1g dose of paracetamol, she did not check the wardex"*

The panel determined that the email sent by the supervising nurse was in the remit of her role, as a coordinator of the ward and she was just feeding back the details of what happened.

The panel considered that Miss Beaumont had a duty to check the correct dosage of all drugs to be given to patients rather than assuming that a standard amount was correct.

The panel found this charge proved.

Charge 3j(i)

"On the 14 May 2020 failed to:

i. Sign for a Nicotine patch that had been administered"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 1's witness statement and oral evidence.

Ms 1 clearly stated in the contemporaneous note written on the same day as the incident, that:

> *'During the medication round one of her she administered a Nicotine patch but did not sign for it. I reminded her after she had completed her round to give her time to realise and come back to it.' [sic]*

The panel noted that Miss Beaumont did not sign for the patch that had been administered at the right time, but as she was supervised, it is likely that at the end of the medication round the patch was signed for, although the panel has no evidence as to who signed for it.

The panel found this charge proved.

Charge 3j(ii)

"On the 14 May 2020 failed to:

ii. Apply 50:50 crème which had been signed as administered"

This charge is found proved.

In reaching this decision, the panel took into account the email evidence, Ms 1's witness statement and her oral evidence.

Ms 1 clearly stated in the note written on the same day as the incident, that:

'She signed for 50:50 crème but did not apply it.'

This was confirmed in her oral evidence.

The panel found this charge proved.

Charge 3j(iii)

"On the 14 May 2020 failed to:

iii. Administer a dose of 30 mg of Chlordiazepoxide."

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

Ms 1 supervision note stated:

"…she was about to dispense a PRN dose of 5mg Chlordiazepoxide however he was due his severe detox dose of 30mg. I had to stop Kay dispensing the 5mg…"

The panel determined that it is unclear whether, after intervention from her supervisor, Miss Beaumont went on to administer the incorrect dose, but the panel considered this to be unlikely.

Therefore, on the balance of probabilities the panel found this charge not proved.

Charge 3k(i)

"On 15 May failed to:

i. Administer medications in a timely manner."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'On this shift I had some concerns about Kay's time management as it took her 90 minutes to do the medication for three patients. She did the medications correctly and escalated, when necessary, but this should have taken her about 30 minutes to do.'*

In Ms 2's contemporaneous note written on the same say as the incident, she stated:

> *'She started the morning with three patients, and it took nearly an hour and a half to administer to all three.'*

Ms 2's oral evidence confirmed this.

The panel determined that it was clear from the evidence that Miss Beaumont did not administer the medication in a timely manner.

The panel found this charge proved.

Charge 3k(ii)

> "On 15 May failed to:
>
> ii. Apply a topical medication before a patient legs were washed"

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

During Ms 2's oral evidence, she stated that Miss Beaumont applied the medication before the patient was washed so after application it was almost immediately washed it off.

The panel determined that it was clear that Miss Beaumont made an error but due to the wording of the charge the panel cannot find this charge proved.

Charge 3k(iii)

"On 15 May failed to:

iii. Set up an intravenous fluid in a timely manner"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 2's note written on the same day as the incident, she stated:
'IV fluids were delayed due to waiting for fluid pump in a patient with BP 81/52 – we have ward runners that could have got one very quickly if prompted to.'

The panel noted the urgent requirement for fluids, as the patient's blood pressure was extremely low and he needed fluids to raise his blood pressure. The panel determined that the IV fluids were not given in a timely manner.

The panel found this charge proved.

Charge 3k(iv)

"On 15 May failed to:

iv. Give a PRN nebuliser at the correct time/interval"

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's contemporaneous note she stated:

> *'Kay was about to given PRN nebs too early, they were prescribed QDS and were not due until 10:00am, Kay was going to administer these at 09:00am which I advised her not to do as it was too early.'*

The panel was of the view that Miss Beaumont intended to give the nebuliser too early but was stopped from doing so by Ms 2 and there is no evidence that indicates when or whether she actually administered the nebuliser.

On this basis, the panel found this charge not proved.

Charge 3k(v)

> "On 15 May failed to:
>
> v. Record the correct code on a Wardex relating to "Ted Stockings""

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's oral evidence.

In Ms 2's contemporaneous note she stated:

> *'Ted stockings not put in place but no omission code put on wardex and patient was later moved.'*

Ms 2 explained in her oral evidence that the TED stockings were not put in place and Miss Beaumont failed to put the code on a Wardex that explained why she had not done so.

The panel determined that Miss Beaumont did not record the correct code on a Wardex relating to TED stockings.

Therefore, the panel found this charge proved.

Charge 3l

> "On one or more occasions gave medications in advance of the time when they were due to be administered."

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'One of the other concerns that came up frequently was Kay wanting to given medication too early.'*

Although Ms 2 stated that one of the issues was that Miss Beaumont administered medication too early, the panel was not provided with evidence of when she had actually administered medication too early, when medications were due to be administered, or in fact which medications were alleged to be involved.

Therefore, the panel found this charge not proved.

Charge 3m(i)

"On 28 May 2020 failed to administer the correct dose of:

i. Oxygen to a patient, namely 0.5 litre."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 1's witness statement and oral evidence.

In Ms 1's contemporaneous note dated 29 May 2020, she stated:

> *'The St/N reported back to Kay that one of her patients was desaturating as he had taken off his 0.5L nasal o2 and asked what she should do. Kay instructed the St/N to administer 2L via the cylinder at the side of the patient. At this time, I intervened and asked Kay what was in the cylinder, she replied 'air'. I asked what would be the result of administering 2L of medical air to the patient and what would be the result. Kay replied that it would increase his o2 saturations but not as quickly as o2. O2 is piped into the ward behind each bed. I then instructed the St/N to re attach the patients nasal o2 which was already on 0.5L and to keep it on 0.5L. The saturations were re checked after 15 minutes and the patients 02 saturations were within range. I informed Kay that administering the Medical air would not have improved the saturations of the patient.'*

The panel determined that there was clear evidence to support this charge.

The panel found this charge proved.

Charge 3m(ii)

"On 28 May 2020 failed to administer the correct dose of:

ii. Medication, namely 25 mg of Sildenafil to a patient."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 1's witness statement and oral evidence.

In Ms 1's contemporaneous note dated 29 May 2020, she stated:

'During the lunch time medications I once again supervised Kay…when Kay was administering to her second patient she removed one of the patient's own medications from the box which was a 50mg tablet of Sidenafil which was prescribed TDS. The patient was only prescribed 25mg... At this time I noted that she had signed that she had administered this drug in the morning. I asked if she had given a full tablet of 50mg and she said yes.'

Ms 1's oral evidence was consistent with her witness statements and exhibits.

The panel determined that there was clear evidence to support this charge.

The panel found this charge proved.

Charge 3n

"On 28 May 2020 failed to recognise the route of administration of a PRN medication was subcutaneous."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 1's witness statement and oral evidence.

In Ms 1's contemporaneous note dated 29 May 2020, she clearly detailed how Miss Beaumont failed to recognise that the route of administration of a PRN medication was subcutaneous.

Ms 1's oral evidence was consistent with her witness statement and exhibits.

The panel noted the two issues that were raised by Ms 1. Firstly, Miss Beaumont proposed putting the medication into a syringe drive, which would have been intravenous. Secondly, Miss Beaumont proposed to administer the medication by IM

(Intra Muscular) injection. In fact, the medication was not prescribed by either of those routes and was instead prescribed for SC (Subcutaneous) administration.

Therefore, the panel found this charge proved.

Charge 3o

> "On 2 June 2020 did not follow instructions from a senior colleague relating to moving/relocating patients."

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 3's oral evidence she said that there may have been *"a bit of confusion on [her] part - it might have been me miscommunicating".*

The panel noted that the evidence relating to this charge gives some details including a change of plan, but was not entirely clear.

The panel found this charge not proved.

Charge 4a(i)

> "On 10 June 2020:
>
> i. Could not explain what Champix (Varenicline) was used for"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's contemporaneous note dated 11 June 2020, she stated:

'Kay did not know what Champix was for, she had to be prompted to know what the drug was for as her patient wanted to go out for a cigarette, Kay thought that the drug was an antibiotic.'

It was clear to the panel that Miss Beaumont did not know what Champix was or what it was used for. Whilst acknowledging that nurse cannot be expected to know details of every drug used, the panel considered that the appropriate step would have been to check the BNF (British National Formulary) before administering a drug that was unfamiliar to her.

The panel found this charge proved.

Charge 4a(ii)

"On 10 June 2020:
ii. In relation to Acyclovir, failed to check a patient's details"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In In Ms 2's contemporaneous note dated 11 June 2020, she stated

'Kay also drew up an IV Aciclovir and went to administer to the patient without checking his details (she stated she had already checked them in the morning)...'

During Ms 2's oral evidence she confirmed that it is standard practice for nurses to check patient details on every occasion before administering medication.

The panel found this charge proved.

Charge 4a(iii)

"On 10 June 2020:
iii. Failed to flush an intravenous line correctly."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'In this shift Kay also did not properly flush the IV. It is standard practice to do a flush of 5 mils before giving the IV medication and then another 5 mils after the medication is given. Kay would have to do this for every medication in an IV. In this instance Kay only did a flush of 2 mils.'*

This was also confirmed in Ms 2's contemporaneous note dated 11 June 2020 and during her oral evidence.

The panel found this charge proved.

Charge 4a(iv)

"On 10 June 2020:
iv. Failed to complete the body mass index (BMI) for a patient".

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'There was also concern during this shift, that was a recurring problem, where Kay would complete a Waterlow score for a patient but it would be incorrect as Kay would not get the BMI of the patient. Most patients are weighed weekly but if*

there wasn't an update weight the nurse would need to weigh the patient to get a correct Waterlow score. Kay had just based her score off what she thought the patient looked like.'

Ms 2's contemporaneous note dated 11 June 2020, she stated:

'Kay completed a waterlow without having a BMI for the patient, the patient had not been weighed since admission…When I advised Kay to weigh the patient the waterlow score changed as it had been calculated incorrectly due to his BMI.'

The panel determined that the evidence clearly shows that the patient was not weighed, and the email indicates the significance of weighing the patient. The Waterlow score was changed based on the incorrect weight.

The panel found this charge proved.

Charge 4b(i)

"On 11 June 2020 failed to:

i. Observe a patient was "Nil by mouth."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 3's witness statement she stated:

'One patient was nil by mouth (meaning they could not take any medication, liquids or food) but Kay went to give them their medication anyway. I had to stop Kay from doing this.'

This was also confirmed in Ms 3's contemporaneous note dated 11 June 2020 and during her oral evidence.

The panel found this charge proved

Charge 4b(ii)

"On 11 June 2020 failed to:
ii. Failed to recognise a patient was to receive Ipratropium"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and her oral evidence.

In Ms 3's witness statement she stated:

> *'During this shift Kay also mixed up the medications for a patient. This was a common mistake and could have been very risky for the patients as they could have received the wrong medication and had an adverse reaction.'*

Ms 3's contemporaneous note dated 11 June 2020, she stated:

> *'The next medication was Ipratropium, Kay got out a 2.5mg Salbutamol and I asked her to check this again…Kay took a moment and then started again without error; however these were near misses.'*

Ms 3's oral evidence also confirmed this.

The panel noted that these instances were categorised as near misses as Miss Beaumont failed to recognise the appropriate medication.

Therefore, the panel found this charge proved.

Charge 4b(iii)

"On 11 June 2020 failed to:

iii. Failed to recognise an unknown medication and/or check its use before administering to a patient"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 3's witness statement she stated:

> *'Another concern was that a patient was prescribed a medication that neither Kay nor I knew what it was. I asked her what she should do in that situation and she just said to check the patient's file to see if there was a leaflet describing the medication. As there was no leaflet for this patient Kay was just going to give the medication anyway as the doctor and pharmacy said it was ok and critical. Kay then asked me to just google what the medication was.'*

During Ms 3's oral evidence she confirmed that it was not acceptable practice to Google but that nurses should check the BNF as this was a professional, regularly updated source relating to all drugs and was readily available on the ward.

The evidence before the panel showed that Miss Beaumont had been preparing to give medication, despite not knowing what it was for and was going to check an unsatisfactory source.

The panel found this charge proved.

Charge 4b(iv)

"On 11 June 2020 failed to:

iv. Failed to escalate a patient with a NEWS score of 5, in a timely manner"

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 3's witness statement she stated:

> *'Another concern during this shift was that a patient had a NEWS of 5 and I asked her to escalate this to the nurse in charge. Kay did not do this until I reminded her later. There was a recurring concern with Kay forgetting things. The policy is to let the nurse in charge know of any changes to NEWS so that they know the status of all patients on the Ward and can let the doctors know.'*

The email goes on to state, *"Kay did however ask the doctor on the ward to review the patient without needing any prompting."* The panel determined that even though Miss Beaumont did not follow procedure she did escalate the patient by asking medical staff for a review.

Therefore, the panel found this charge not proved.

Charge 4c(i)

"On 12 June:

i. Failed to take any or any adequate action regarding a patient suffering from chest pains"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 3's written statement she stated:

'In the handover for this shift Kay was told that a patient was having chest pains. Knowing this, Kay started her shift by doing the medications round.'

In Ms 3's oral evidence she confirmed in detail the steps that Miss Beaumont should have taken when she was informed that the patient had chest pains during handover, and that the patient should have been prioritised.

The panel determined that Miss Beaumont had a duty to prioritise this patient, with potentially life threatening symptoms, and she failed to do so.

The panel found this charge proved.

Charge 4c(ii)

"On 12 June:
ii. Did not complete the medication round in a timely manner."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

The panel noted that in Ms 3's written statement and contemporaneous supervisory note, she explained how the medication round for eight patients took Miss Beaumont nearly three hours to complete and she regarded this as an excessive amount of time.

Therefore, the panel found this charge proved.

Charge 4c(iii)

"On 12 June:
iii. On one or more occasions failed to check the identity of a patient, before administering medication.

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

Ms 3 in her witness statement stated:

> *"Senior Nurse… told me that Kay wasn't checking name, DoB and hospital number before giving medication"*

The panel noted that the incident was reported by this nurse to Ms 3, and so was hearsay. However, the nurse was a senior nurse who was supervising Miss Beaumont at the time of the incident, and she reported it to Ms 3 close to the time. The panel felt that there was no reason to doubt her observations. The panel determined that this was strong hearsay evidence.

The panel found this charge proved.

Charge 4d(i)

"On 15 June 2020:

i. Demonstrated poor communication skills in relation to washing a patient"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'On this shift there was again concern that Kay wasn't communicating with the carer assigned to her. This lack of communication led to one patient not being washed until after 17:00 as there was confusion as to who was doing what.'*

In Ms 2's contemporaneous note dated 15 June 2020, she stated:

'Bed 3 has still not been washed (it is 17:05) Kay did speak with Marie and Marie was under the impression that Kay was washing bed 3 as she wanted to check his skin.'

Ms 2 was clear in her evidence that Miss Beaumont did not make it clear for the HCA, to know which patient to wash.

The panel found this charge proved.

Charge 4d(ii)

"On 15 June 2020:

ii. Caused a cannula to be removed from a patient's arm."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 3's witness statement and oral evidence.

In Ms 2's evidence she explained that she was taking bloods from the patient when Miss Beaumont arrived, and without saying anything, began to try to remove the patient's top. Ms 2 stated, *"she was trying to cool him [patient] down, and she was being caring...but I told her to let me finish but she continued anyway"*.

In Ms 2's written statement she stated:

'I told her to stop as I was taking blood but she kept trying to take the shirt off. This caused the patient's cannula to come out and I had to re-insert it.'

The contemporaneous note and oral evidence confirmed that Miss Beaumont knocked the patient's cannula out whilst taking off his top.

The panel found this charge proved.

Charge 4e(i)

"On 15 June failed to:

i. Recognise that the medication, namely Frusemide, should not be administered to a patient."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's oral evidence she stated:

> *'Furosemide is a basic medication that Kay should be familiar with. It is a diuretic so helps the body excrete excess fluid if the heart is not working very well. At it is a diuretic, you need to make sure that the patient doesn't get dehydrated. Kay should have known that giving this medication to someone who has been vomiting all night could be dangerous.'*

The contemporaneous note dated 15 June 2020 also confirms that the patient had been vomiting all night and that Ms 2 advised Miss Beaumont to review the medication before administering.

Ms 2's oral evidence confirmed the evidence.

The panel found this charge proved.

Charge 4e(ii)

"On 15 June failed to:

ii. Record the reason for not administering Bisoprolol"

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In the supervisory note sent from Ms 2 sent on 15 June 2020, it states:

> *"Bed 3 – went to give bisoprolol (dispensed into pot) even though already given by night staff realised, as she went to sign…"*

However Ms 2, in her oral evidence, said that Miss Beaumont did not need to record anything as there was already a record of the drug's administration, and that all that Miss Beaumont needed to do was to dispose of the tablet. Upon questioning from the panel, Ms 2 further stated that she made an error in her witness statement and confirmed that recording the reason for not administering the medication was not required.

On this basis, the panel found this charge not proved.

Charge 4e(iii)

"On 15 June 2020 failed to:

iii. Dispose of Bisoprolol correctly and /or in a timely manner."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's contemporaneous note dated 15 June 2020, she stated:

> *'Bed 3 – went to give bisoprolol (dispensed into a pot) even though already given by night staff as high BP, realised when she went to sign and then disposed of the tablet into her pocket, she said she would get a sharps bin afterwards for her drug trolly, I advised her we were based by the sluice which had a sharps bin in it and she should dispose of it there.'*

During Ms 2's oral evidence she explained the correct disposal procedure which should have been used; this was to place unwanted medication in the sharps bin immediately.

The panel considered that safe disposal of unused drugs should be a well known procedure for registered nurses.

The panel found this charge proved.

Charge 4e(iv)

"On 15 June 2020 failed to:
iv. Complete documents for a new admission"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'There had been a new admission at 17:00 and Kay did not properly document his arrival to the Ward or complete any other documentation by the time of the night shift handover at 19:30.'*

In Ms 2's contemporaneous note dated 15 June 2020, she stated:

> *'Kay has had a new admission at 17.00hrs - has not documented his arrival to the wards, Kay has not completed his body map, not any of his paperwork.'*

The panel determined that the documentation confirms that Miss Beaumont had not done any of the required paperwork.

The panel found this charge proved.

Charge 4e(v)

"On 15 June 2020 failed to:
v. Disconnect a patient from an insulin pump."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'There was another patient during the medications round who Kay stopped their insulin pump as needed but she did not disconnect it from the patient. I don't know if there is a risk in this but it is best practice to disconnect it as it could get knocked off.'*

The contemporaneous note dated 15 June 2020 also confirms that Miss Beaumont stopped the patient's insulin pump but did not disconnect it and that, *"this was dangerous as the fluid is specific to the sliding scale and she should disconnect the whole sliding scale and dispose of it"*

Therefore, the panel found this charge proved.

Charge 4e(vi)

"On 15 June 2020 failed to:
vi. Prepare a medication correctly, namely intravenous Ondansetron"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

Ms 2 in her witness statement stated:

'Kay also drew up IV Ondansetron incorrectly as she diluted it with water instead of saline. The medications book is very specific as to how it is to be drawn up.'

During Ms 2's oral evidence, she stated that the medications book gives very specific detail on how to prepare the medication correctly.

The contemporaneous note dated 15 June 2020 also confirms this.

The panel determined that it was clear that Miss Beaumont had drawn up the IV medication incorrectly, and that should have been diluted with saline instead of water.

The panel found this charge proved.

Charge 4e(vii)

"On 15 June 2020 failed to:
vii. Administer a topical 50:50 cream at the correct time."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

The contemporaneous note dated 15 June 2020 states:

'Bed one: 50:50 cream found by the sink at around 15.00 Kay stated she left it there and forgot to put it away, she had used it on the patient even though it was not prescribed at that time as I had already signed for it and administered it on the morning medication round.'

The panel considered that if the cream had not been prescribed for the afternoon drugs round then it should not have been given.

The panel found this charge proved.

Charge 4f(i)

"On 16 June 2020 failed to:

i. Carry out morning observations and/or care rounds on one or more patients"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's contemporaneous email dated 16 June 2020, she listed the six beds and side rooms where Miss Beaumont did not complete the care rounds.

The panel determined that the evidence clearly indicated that Miss Beaumont did not carry out morning care rounds.

Therefore, the panel found this charge proved.

Charge 4f(ii)

"On 16 June 2020 failed to:

ii. Complete a new care plan for a new catheter"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

Ms 2's contemporaneous email dated 16 June 2020, refers to one of Miss Beaumont's patients who had a blocked catheter. This states:

'… No new care plan for catheter in place.'

During Ms 2's oral evidence she clarified and confirmed that every patient should have a catheter care plan.

On this basis, the panel found this charge proved.

Charge 4f(iii)

"On 16 June 2020 failed to:
iii. Sign the oxygen scale in a patient's Wardex"

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'During the morning medications round Kay did not sign for the oxygen scale referring to the scale in the patient Wardex. If a patient needs oxygen, then it must be prescribed by a doctor. Signing the oxygen scale is a common thing that Kay would do every medication round. However, to be fair it was still a fairly new system but it was something Kay had done before.'*

In Ms 2's contemporaneous email dated 16 June 2020, she stated:

> *'Bed 2: has not signed o2 scale – has not noticed that o2 scale is not prescribed...Bed 3: did complete o2 scale…bed 6: Kay has completed his o2 scale on the wardex'*

Although Ms 2 witness statement alludes to Miss Beaumont not signing the scale, the panel determined that the email indicates that two of the oxygen scales were completed and one oxygen scale was not prescribed.

In view of this confused evidence, the panel found this charge not proved.

Charge 4f(iv)

"On 16 June 2020 failed to:

iv. Carry out any or any adequate checks on a patient who was later found deceased"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'…patient was found deceased. When I found the patient I followed protocol and laid them flat with one pillow under their head. I noticed at this time that they were already going stuff [sic] so I knew they had passed some time before. When I asked Kay about the patient she said she had looked in on him an hour prior but hadn't actually went and checked on him.'*

In Ms 2's contemporaneous email dated 16 June 2020, she stated:

> '*I asked Kay when she last checked on the patient and said she had popped her head round the door at 8.15 but hadn't actually checked, I feel the patient may have passed away a while ago.'*

Ms 2 was also asked about this incident during her oral evidence and she described in detail what had happened and reiterated that the patient must have passed away some time before he was found due to the onset of rigor mortis when she found him.

The panel found this charge proved.

Charge 4f(v) & 4f (vi)

"On 16 June 2020 failed to:

v. Carry out a blood sugar check in a timely manner, for one or more patients;
vi. Administer insulin in a timely manner, namely before breakfast"

These sub-charges are found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'The patient should have had their blood sugar checked and been given their insulin before their breakfast. However, Kay didn't give the patient their insulin until quite late.'*

In Ms 2's contemporaneous email dated 16 June 2020, she stated:

> *'This gentleman is due insulin, he had his breakfast an hour and half ago… I asked if there is anything we could have done better and she advised me that he should have has his insulin before breakfast and we should have come to him first instead of last.'*

The panel noted that the evidence indicates that the patient needed a blood sugar test before being administered insulin, but Miss Beaumont did not do that and she failed to give his insulin before the patient had breakfast.

The panel found both charges proved.

Charge 4f(vii)

"On 16 June 2020 failed to:
vii. Administer codeine, at the correct time, and/or, not one or more hours in advance of the due time"

This charge is found proved.

In reaching this decision, the panel took into account Ms 2's witness statement, her email sent the day following the incident and her oral evidence.

In Ms 2's witness statement she stated:

> *'There were also some medications given 45 minutes late, a near miss with giving a medication not prescribed until the next day, and Kay also gave a patient their codeine two hours early.'*

In Ms 2's email she wrote the day after the incident, she stated:

> *'Bed 2: went to give codeine two hours early, had to stop her from signing them out of the book (made the same near miss yesterday with the same patient).'*

The panel determined that this charge is found proved on the basis that Miss Beaumont failed to administer codeine at the correct time.

Charge 4f(viii)

"On 16 June 2020 failed to:

viii. Administer a medication at the correct time and/or day"

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'There were also some medications given 45 minutes late, a near miss with giving a medication not prescribed until the next day.'*

The supervisory email sent the same day states, *"pharmacist informed Kay at 09:45 that Bisoprolol can be crushed. At 10:50 I had to remind Kay that this was still due…At 10:35 Kay said that the medication round was done…I advised her that the Bisoprolol has still not been given and the uniphyllin is still to be given…uniphyllin administered at 10:45. Bisoprolol administered at 10:50."* And later, *"IVABX given at 12:45…when they were due at 12:00…Benzyl penicillin due at 12:00 administered at 13:00."*

The panel determined that there was sufficient evidence to demonstrate that mediations were being given late.

On this basis, the panel found this charge proved.

Charge 4f(ix)

"On 16 June 2020 failed to:

ix. Remove the correct medication patch from a patient, namely a Glyceryl Trinitrate (GTN) patch."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'Kay had also removed the wrong medication patch from a patient. Kay was supposed to remove the GCN patch but actually removed the pain patch.'*

Ms 2's oral evidence and her contemporaneous email also confirmed this.

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

Charge 4g(i)

"On 17 June 2020 failed to:

i. Recognise that a dose of medication was no longer prescribed, namely Amlodipine."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's supervisory note dated, 17 June 2020, she stated:

> *'Bed 4: noted ramipril had been started and administered stated she was going to administer amlodipine too but had to stop her as it had been rewritten.'*

The panel therefore found this charge proved.

Charge 4g(ii)

"On 17 June 2020 failed to:

ii. Administer a medication namely codeine, at the correct time."

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's supervisory note dated 17 June 2020, she stated:

> *'Bed 2: went to give codeine two hours early, had to stop her as it had been rewritten.'*

The panel noted that as Miss Beaumont was stopped when she was about to administer the medication early, she did not actually do so. The panel was not taken to evidence as to whether it was administered at the correct time.

The panel therefore found this charge not proved.

Charge 4g(iii)

"On 17 June 2020 failed to:

iii. To store a medication correctly, namely a liquid antibiotic."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's supervisory note dated 17 June 2020, she stated:

> *'Bed 1: Had to advise the liquid abx needed to be stored in the fridge as she put it away in drugs trolley.'*

During Ms 2's oral evidence she confirmed that nurses were required to store certain medications in the fridge, including the liquid antibiotic.

The panel found this charge proved.

Charge 4h(i) & 4h(ii)

"On 23 June 2020, failed to:

i. Record observations in official records;
ii. Complete records accurately and/or in a timely manner."

This charge is found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 3's witness statement she stated:

'However, I had concerns about Kay writing observations down on a piece of paper and then not transferring these to the official charts.'

Ms 3 also stated in her oral evidence that on occasions Miss Beaumont had written her observations down on a paper towel and although this was not uncommon during covid, she was aware that she must transfer them immediately to official records.

In Ms 3's supervisory note dated 23 June 2020, she stated:

'Kay had taken a blood sugar and observations and ECG. I have not been able to find where Kay has documented these observations. (I have asked Kay about this and she states that she did forget to document them).'

'Kay documented observations taken at 1010, at 1345 however the time of these observations is recorded as 1110, additional observations recorded as 1125, however these were taken at 1025'

The panel were clear that Miss Beaumont failed to record observations and complete records in a timely manner.

The panel found both of these charges proved.

Charge 4i(i) & 4i(ii)

"On 15 July 2020 in relation to a patient with a haemoglobin level of 61 failed to handover information:

i. To another colleague relating to the patient's condition;
ii. Relating to the patient receiving 2 units of blood.

Charge 4(i) is found proved and Charge 4(ii) is not found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

In Ms 2's witness statement she stated:

> *'For one patient Kay told me their information but did not handover that their haemoglobin level (HB) was 61 and that they were waiting on two units of blood. I only found this out from another nurse. An HB of 61 means that the patient will be a priority for treatment.'*

Ms 2's supervisory email, dated 15 July 2020 also confirmed this.

On this basis, the panel found Charge 4(i) proved but find Charge 4(ii) not proved since it refers to the patient receiving two units of blood but in fact the patient was waiting for the two units of blood.

Charge 4j

> "On 15 July 2020 did not recognise that the dose of antibiotics prescribed for a patient was low."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

Ms 2's witness statement stated:

> *'I had also questioned a dose of antibiotics that was prescribed to a patient as I knew it was too low. I highlighted this to Kay and she didn't seem to think it was necessary to escalate to the medics.'*

Ms 2's supervisory email dated 15 July also confirmed this.

The panel found this charge proved.

Charge 4k

"On 15 July 2020 failed to escalate to a doctor a patient with a CIWA score of 10 to, in a timely manner."

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

Ms 2's witness statement stated:

> *'As withdrawal can be hard and painful it is normal to give medications such as Librium to reduce the symptoms as well as reduce the risk of seizure. Kay did not understand that this patient should get some medication.'*

In Ms 2 supervisory note dated 15 July 2020, she stated:

> '*Another patient had a CIWA score of 10 but Kay did not act on it'.*

During Ms 2's oral evidence she explained that patients experiencing alcohol withdrawal symptoms evidenced by a high CIWA score may need medication both to alleviate discomfort and prevent potential seizures. Miss Beaumont should have escalated this patient to the medics in a timely manner due to the high CIWA score.

The panel noted that the passage in Ms 2's witness statement also describes the importance of referring patients with a CIWA score of 10 to a doctor so that they can have medication prescribed.

The panel found this charge proved.

Charge 4l(i-iv)

"On 15 July 2020 in relation to a patient with a NEWS score of 4 failed to:

i. Escalate to a doctor in a timely manner;
ii. Provide a doctor with the patient's history relating to tachycardia and/or low blood pressure;
iii. Administer medication, namely Digoxin in a timely manner;
iv. Set up an Intravenous infusion for the patient;'

These sub-charges are found proved.

The panel considered each of these charges separately but as the evidence in relation to each is similar it has dealt with them under one heading.

In reaching this decision, the panel took into account documentary evidence, Ms 2's witness statement and oral evidence.

Ms 2's witness statement stated:

> *'Another patient during the morning medications round had a NEWS score of 4 due to low blood pressure and a heartrate of 129. Kay said that she would put the patient on two hourly observations and would escalate to the medics. Kay then continued her medications round without alerting the medics. Later on Kay did escalate to the medics and told them that the patient was in pain but she didn't tell them that the patient had tachycardia or had low blood pressure.'*

In Ms 2 supervisory note dated 15 July 2020, she stated:

> *'Whilst doing the morning medications we got to bed 6 and Kay completed her observations she informed me that the patient had a NEWs 4 due to low BP and HR of 129… she DID NOT inform them that patient had an acute tachycardia nor did she express any concern to the medics.'*

‘Medics prescribed stat dose of digoxin for this patient at 09.40 – Kay administered this at 10.35, Kay did not notice that they had also prescribed IVI for this lady so I put the fluids up.’

The panel considered that they had been informed that doctors were always on the ward and that it was therefore Miss Beaumont’s duty to escalate patients with a NEWS score of 4 and above immediately. A full explanation of the patient’s condition was required so that a doctor could make an accurate assessment of actions needed. The panel determined that a delay of 55 minutes in administering medication (that was specifically to reduce acute tachycardia) was excessive and untimely. Miss Beaumont had also failed to put up an IVI even though this had been prescribed.

The panel therefore found these sub-charges proved.

Charge 4l(v)

“On 15 July 2020 in relation to a patient with a NEWS score of 4 failed to:

v. Ensure a Telemetry box for the patient was able to measure/transmit.”

This charge is found proved.

In reaching this decision, the panel took into account documentary evidence, Ms 2’s witness statement and oral evidence.

Ms 2’s witness statement stated:

‘same patient as above with the tachycardia needed a telemetry box. A telemetry box is a heart monitor that the results go straight to the cardiology ward. This patient was to be monitored 24 hours a day but it was noted that their telemetry box had a dead battery and the patient didn’t have any readings over the previous night. Kay took over to try and find a new battery for the box. It was later on in the shift that I checked in with her to see if she got one and Kay said that

she had checked and no one had a spare battery so she would just call again later.'

In Ms 2 supervisory note dated 15 July 2020, she stated:

'I also had to change her telemetry box as the one on the patient was not working at all, Kay did not check this at the start of her shift…I informed Kay this was the wrong thing to do as patient was tachycardic and needed close monitoring on telemetry (medics had also informed her of this).'

The panel considered that although the box was not working, Miss Beaumont should have checked the box at the start of her shift and in view of the patient's changing condition, made it a priority to ensure the telemetry was working.

The panel found this charge proved.

Charge 4m(i)

On 21 July 2020 in relation to a new admission at 08:05 hrs failed to:

i. Complete the admission of the patient;

The panel found this charge proved

The panel considered the witness statement of Ms 2 and the supervisory email written on 21 July 2020 and her oral evidence.

Ms 2 in her witness statement stated that:

"Kay again had trouble finishing new patient documentation in a timely manner"

The email written on 21 July 2020 stated:

"Kay received a new admission at 0805 she didn't complete her admission until 1145 (no other patients acutely unwell and by this point Kay only had the lady in the sideroom)"

She documented that Kay advised that she could not complete the front page as the patient did not speak English, but *"when I checked the paperwork none of the admission had been completed."*

The panel therefore found this charge proved.

Charge 4m(ii)

ii. Ensure the patient received intravenous fluids in a timely manner.

The panel found this charge proved

The panel considered the supervisory email written by Ms 2 on 21 July 2020 and her oral evidence.

In Ms 2's supervisory email it states:

"IV fluids were ordered by Kay urgently at 1000 as none on the ward however, at 13.30 I asked her if she had put them up she said they hadn't come up yet from pharmacy (they had been sat in a bag in the clean utility since around 10.30) Kay had not chased this up so these were delayed for 3 hours on a lady who was malnourished for three hours and had not eaten and drank for 10 days." [sic]

This was confirmed in Ms 2's oral evidence.

The panel therefore found this charge proved.

Charge 4n)i)

n) On one or more occasions failed to use 3 patient identifiers, namely name, date of birth, and hospital/NHS number on each page, namely on:
    i) 28 July 2020;

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her witness statement stated:

> *"The next shift I supervised Kay was 28 July 2020. During this shift there were no mistakes during the morning medications round but I did have to remind Kay to concentrate. I also had to remind Kay several times that when writing documentation she needs to have three patient identifiers (such as name, date of birth and hospital or NHS number) on every page…"*

Ms 3 reiterated this in her oral evidence.

The panel also noted that Ms 3, in an email written contemporaneously on 28 July 2020, stated:

"Documentation: I have pointed out a couple of times today that Kay needed to check that dates were on documentation and that there were 3 patient identification details the paperwork". Later in the same email, Ms 3 stated that *"…Kay still needs to ensure her documentation is completed correctly with patient identification details on…"*

In light of the above, the panel was satisfied, on the balance of probabilities, that on 28 July 2020 on one or more occasions Miss Beaumont failed to use 3 patient identifiers, namely name, date of birth, and hospital/NHS number on each page.

Therefore the panel found this charge proved.

Charge 4n)ii)

n) On one or more occasions failed to use 3 patient identifiers, namely name, date of birth, and hospital/NHS number on each page, namely on:
    ii) 30 July 2020.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her witness statement stated:

> *"The next shift that I supervised Kay was on 30 July 2020. I again had concern on this shift about Kay not checking the patient's details before giving them their medication…"*

Ms 3 reiterated this in her oral evidence.

The panel also noted that Ms 3, in an email written contemporaneously on 30 July 2020, stated*:*

> *"I have also had to remind Kay about making sure that paperwork has 3 patient identification details, which we had discussed on the 28/7/20 in detail during daily feedback and this is something I have raised with her on previous shifts…."*

In light of the above, the panel was satisfied, on the balance of probabilities, that on 30 July 2020 on one or more occasions Miss Beaumont failed to use 3 patient identifiers, namely name, date of birth, and hospital/NHS number on each page.

Therefore, the panel found this charge proved.

Charge 4o)i)a)b)c)

o) On 5 August 2020:

i) Gave inaccurate patient information during a handover relating to;

a) NEWS scores;

b) Intravenous Antibiotics (IVAB);

c) Patients medication.

These sub-charges are found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her witness statement stated:

> *"The next shift I supervised Kay on was 5 August 2020…Kay again was getting distracted during the medications round by making conversation with colleagues. I also had to give a lot of support and guidance to Kay this shift. At the evening handover Kay gave a lot of incorrect patient information to the next shift. This was a recurring issue. We all have a handover sheet that we can write our notes on. There was no reason why Kay would not be able to give correct patient information as she would have her notes on her. We are not expected to remember everything off to top of our heads so it is ok to check your notes."*

Ms 3 reiterated this in her oral evidence.

The panel also noted that Ms 3, in an email written immediately after Miss Beaumont's shift on 5 August 2020, stated:

> *"Kay's evening handover to the night staff was not without error. She handed over incorrect NEWS scores for patients, incorrect times for IVAB, incorrect drugs that the patient was on. I have had to handover the correct information to the night staff."*

In light of the above, the panel was satisfied, on the balance of probabilities, that on 5 August 2020, Miss Beaumont gave inaccurate patient information during a handover relating to NEWS scores, IVAB and patients' medication.

Therefore the panel found these sub-charges proved.

Charge 4o)ii)

o) On 5 August 2020:

ii) Did not recognise how to improve the low blood pressure of a patient, namely by altering the patient's position;

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

The panel noted that Ms 3, in an email written contemporaneously on 5 August 2020, stated:

> *"…throughout the day thus far I have had to provide a lot of support and guidance to Kay in terms of prioritising to assist time management. At one point I was discussing the patient who had a NEWS of four with her and asking if there was anything she could do for the patient as the BP was low as the doctors were not on the ward. Kay said she had encouraged the patient to drink more. I also prompted that she could tilt the bed so the legs were elevated to help improve the BP. I advised that Kay had completed her ILS now so she should use these principles to manage a deteriorating patient…"*

Ms 3 reiterated this in her oral evidence. She stated it is basic practice for a registered nurse to know how to increase a patient's blood pressure.

In light of the above, the panel was satisfied, on the balance of probabilities, that on 5 August 2020, Miss Beaumont did not recognise how to improve the low blood pressure of a patient, namely by altering the patient's position.

Therefore the panel found this charge proved.

Charge 4o)iii)

o) On 5 August 2020:

iii) Failed to complete a Waterlows score (Pressure Ulcer Risk assessment chart);

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her witness statement stated:

> *"The last shift that I supervised Kay on was 6 August 2020...At the start of the shift the night staff handed over that Kay had not completed eight waterlows the previous shift and two patients did not have VIP charts…"*

Ms 3 in her oral evidence stated that waterlow scores are usually completed after the morning wash rounds and by the end of the day they had still not been completed.

The panel noted that Ms 3, in an email written contemporaneously on 5 August 2020, stated*:*

> *"…As of 1930. Kay has still got documentation to complete for today she has not yet started her Waterlows…"*

In light of the above, the panel was satisfied, on the balance of probabilities, that on 5 August 2020, Miss Beaumont failed to complete a Waterlows score.

Therefore the panel found this charge proved.

Charge 4o)iv)

o) On 5 August 2020:

iv) Did not identify a patient by their ID band before administering Codeine.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

The panel noted that Ms 3, in an email written contemporaneously on 5 August 2020, stated:

> *"A patient needed codeine this afternoon, Kay dispensed this correctly but on administering. I heard her ask for the DOB but Kay did not check the patients wristband and she did not have the DOB written down or Hospital number to confirm this was the right patient. Checking patient details prior to medication administration is something that has been brought up repeatedly to Kay…" [sic]*

In light of the above, the panel was satisfied, on the balance of probabilities, that on 5 August 2020, Miss Beaumont did not identify a patient by their ID band before administering Codeine.

Therefore the panel found this charge proved.

Charge 4p)i)

p) On 6 August 2020 failed to:

i) Check the blood sugar levels for one or more patients;

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

The panel noted that Ms 3, in an email written contemporaneously on 6 August 2020, stated*:*

> *"Kay communicated a plan with her HCA this morning it was more detailed than the previous two days which is good to see Kay has taken on board the feedback that has been provided. However Kay did say to the HCA that there are no blood sugars, however Kay has two diabetic patients and one patient that is NBM that will need blood sugars checking today which I have highlighted to the HCA." [sic]*

The panel bore in mind that the charge stated that Miss Beaumont failed to check the blood sugar levels, however there is no evidence to suggest that she did not do this. Additionally, it appears to the panel that the HCA did this.

The panel reminded itself that it is for the NMC to prove the charge. The panel noted that Ms 3's contemporaneous email suggests that Miss Beaumont had not told the HCA that there were blood sugar levels of patients to check. Further, it was Ms 3 that highlighted the need to do this to the HCA. However, the panel was could not be satisfied that, on the balance of probabilities, on 6 August 2020 Miss Beaumont had a duty to check the blood sugar levels for one or more patients.

Therefore the panel found this charge not proved.

Charge 4p)ii)

p) On 6 August 2020 failed to:

ii) Administer anticipatory medication to a patient;

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her witness statement stated:

> *"Another concern this shift was that Kay had a patient who was on end of life care and had been prescribed medication for their agitation. Kay knew that the medication was available but did not give it right away. Kay said that the patient was just as agitated as they had been the day before so it wasn't an issue. However, Kay now had medication prescribed that could help the patient have a dignified end of life and could improve the quality of care. I didn't want to take over the patient from Kay and I tried to prompt her to think more about it. But I couldn't stand the thought of the patient being agitated so I arranged for SSR…to give the medication with me. Once anticipatory medications were available, they should be given as required in End of Life Care."*

Ms 3, in her oral evidence, reiterated this in detail.

The panel noted that Ms 3, in an email written contemporaneously on 6 August 2020, stated:

> *"…One patient has been put on End of Life Care this morning, which was the patient that had a NEWS of 8 earlier today. This patient was showing signs of agitation when Kay nursed him yesterday and is continuing to do so today. I had already asked the doctors this morning to prescribe anticipatory medications due to his agitation before he was commenced on the EOL pathway. During the afternoon drug round I said to Kay the patient continues to be agitated and said let's check if the anticipatory medications had been prescribed which we found that they had. Kay continued to move on to other patients medication completing these for the afternoon round. I verbalised to Kay that I was concerned that this patient was dieing and was agitated so whilst she gave her other patient her medications I would ask SSR …to join me to give a controlled drug medication to help try settle his agitation as this was a priority. Kay stated to me after SSR…and I had given the medication that she did not think it was fair that we had done that because he was no more agitated than yesterday and she was not*

neglecting him. I explained to Kay that this gentleman is on EOL and is agitated throwing his arms up and down in the bed so we need to make sure he is comfortable and dignified at this time in his life. I explained that although these are her patients and I am here to supervise her, patients are still my priority and this patients comfortable needed to be addressed. I explained that he may also be in pain and this could be causing the agitation so she would need to check on the patient to see if the midazolam has helped and consider analgesia if not. Kay did come to me later on and ask if we could administer morphine as he was still not settled…" [sic]

In light of the above, the panel was satisfied that on 6 August 2020, Miss Beaumont failed to administer anticipatory medication to a patient.

Therefore the panel found this charge proved.

Charge 4p)iii)

p) On 6 August 2020 failed to:

iii) Indicate that a medical record was made retrospectively:

This charge is found not proved.

The panel was of the view that there is no specific evidence to support this charge.

Therefore the panel found this charge not proved.

Charge 4p)iv)

p) On 6 August 2020 failed to:

iv) Indicate that a Waterlows score for 5 August 2020 was completed retrospectively;

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her oral evidence stated that Miss Beaumont had completed the Waterlows required on 6 August 2020. However, on the same day (6 August) she had also completed the Waterlows she had forgotten to do on 5 August, and dated it 5 August.

The panel noted that Ms 3, in an email written contemporaneously on 6 August 2020, stated:

> *"On reviewing documentation this evening. I have noted that Kay has completed her waterlows for today but has also filled in her waterlows that she did not completed dating and timing them with yesterday's date." [sic]*

In light of the above, the panel was satisfied, on the balance of probabilities, that on 6 August 2020, Miss Beaumont failed to indicate that a Waterlows score for 5 August 2020 was completed retrospectively.

Therefore the panel found this charge proved.

Charge 4p)v) and 4p)vi)

p) On 6 August 2020 failed to:
   v) Carry out Visual Inspection of Phlebitis (VIP);
   vi) Record observations in (VIP) charts;

These sub-charges are found not proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her witness statement stated:

"The last shift that I supervised Kay on was 6 August 2020…At the start of the shift the night staff handed over that Kay had not completed eight waterlows the previous shift and two patients did not have VIP charts. A VIP chart is the "visual inspection of phlebitis" and is where you document the cannula site for a patient. You need to document this twice a day shift for each patient .You also would physically inspect the area before giving any mediation. Kay may have been inspecting the site but there was no documentation of this…"

The panel noted that Ms 3, in an email written contemporaneously on 6 August 2020, stated:

"Noted by night staff from yesterday that Kay had only completed 1/8 waterlows and two patients did not have VIP charts."

The panel bore in mind that the sub-charges stated that Miss Beaumont failed to carry out VIP's on 6 August 2020 and record VIPs on 6 August 2020. However the email from Ms 3 stated that Miss Beaumont failed to do this "yesterday", namely, on 5 August 2020.

In light of the above, the panel was of the view that there is no specific evidence to prove these sub-charges.

Therefore the panel found these sub-charges not proved.

Charge 4p)vii)

p) On 6 August 2020 failed to:

vii) To have a stethoscope that could be used whilst on duty;

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her witness statement stated:

> *"On this shift a doctor had asked Kay to manually get a blood pressure for a patient but Kay again did not have her stethoscope..."*

[PRIVATE]

The panel noted that Ms 3, in an email written contemporaneously on 6 August 2020, stated:

> *"…The consultant raised to me about the patient who had a low BP yesterday and said he would have liked a manual reading to confirm it and if it occurs today this will need to be done. I have raised this with Kay and discussed that I suggested to her yesterday that she confirmed it manually but she had not done so. Kay stated that she didn't have her stethoscope with her…"*

In light of the above, the panel was satisfied, on the balance of probabilities, that on 6 August 2020, Miss Beaumont failed to have a stethoscope that could be used by her while on duty.

Therefore the panel found this charge proved.

Charge 4p)viii)

p) On 6 August 2020 failed to:

viii)Administer medication in a timely manner;

This charge is found not proved.

The panel was of the view that there is no specific evidence to support this charge.

Therefore the panel found this charge not proved.

Charge 4p)ix)

p) On 6 August 2020 failed to:

ix) Inform a doctor of the complete clinical details of a patient;

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her witness statement stated:

> *"…When Kay spoke to the doctor about the patient she told them the NEWS but did not give them the full picture of the patient …"*

Ms 3 reiterated this in her oral evidence. She provided the panel with detailed evidence pertaining to the background information that was needed for the doctor to make recommendations for the next steps.

In light of the above, the panel was satisfied, on the balance of probabilities, that on 6 August 2020, Miss Beaumont failed to inform a doctor of the complete clinical details of a patient.

Therefore the panel found this charge proved.

Charge 4p)x) and 4p)xi)

p) On 6 August 2020 failed to:

x) Complete step B of the ABCDE assessment of a the patient;

xi) Take adequate action relating to the patient's deteriorating condition;

These sub-charges are found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her witness statement stated:

> *"…I asked Kay to do an ABCDE assessment. This is to assess A (airway) B (breathing) C (circulation including blood pressure, heart rate, chest pain, temperature and urine output) D (disability including blood sugars, pupil responses, alertness, responses to pain and looking for confusion) and E (exposure looking at any recent medicine given, rashes and doing a head to toe review)… Kay was unfamiliar with the steps of the assessment and lacked situational awareness in terms of patient safety that he needed to be assisted back into bed in case of further deterioration. Kay could also have given the patient a nebuliser to help open their airways. In her assessment Kay had missed the B step and gone right to C and to give IV fluids, which were required but B steps should have bene [sic] prioritised first in order of treatment.*
>
> *It is my belief that had I not been here to supervise Kay that the patient's deterioration may have gone unnoticed…"*

Ms 3 provided detailed oral evidence. She stated that Miss Beaumont had missed step B of the ABCDE assessment and went straight to step C. She explained that there was a series of actions that should have been taken in relation to step B related the patients deteriorating condition which had not been carried out by Miss Beaumont.

The panel noted that Ms 3, in an email written contemporaneously on 6 August 2020, stated:

> *"…I asked Kay to talk me through her ABCDE assessment of the patient whilst she waited for the doctor to see the patient. I had to prompt Kay through this and remind her that the patient had PRN NEBS prescribed which would be of benefit to the patient now. The doctor arrived at this point and agreed with me that a*

NEB needed to be given and that she had also prescribed some slow IVI as they needed to be cautious with this. Kay went to get the IVI and I got the NEB which was the priority at this point. I have continued to monitor the patient myself and have managed to decrease the 02 requirements again and BP has improved. I am concerned that had I not been supervising Kay today this patient may have deteriorated further due to not monitoring the SATS but also relying on the doctor to formulate a plan of management initially when there where actions she can do to support the patient first…"

The panel also bore in mind that at this stage, Miss Beaumont had already successfully completed intermediate life support training. As a result, the panel was satisfied that she should have known what to do in these circumstances.

In light of the above, the panel was satisfied that on 6 August 2020 Miss Beaumont failed to complete step B of the ABCDE assessment of the patient and take adequate action relating to the patient's deteriorating condition.

Therefore the panel found these sub-charges proved.

Charge 4p)xii

p) On 6 August 2020 failed to:

xii) Correctly programme equipment for Intravenous medication.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3.

Ms 3 in her witness statement stated:

"…I was alerted that Kay had incorrectly programmed and IV medication for a patient that was due at 6:30 PM on 6 August 2020 [sic]… The machine for giving IV medication requires the nurse to input what medication they have and then check all the parameters are correct. Kay had not put in the correct information

and didn't notice. Because of this the medication was delayed until 8:30 PM. This can be a real risk for the patient as this medication was an antibiotic which is a critical medication which in this case had been delayed by two hours due to the error…"

The panel took account of the contemporaneous DATIX incident form completed on 6 August 2020. Under the title "Incident Description" confirmed that the IV medication was found to be programmed incorrectly and the medication was delayed by two hours.

In light of the above, the panel was satisfied that on 6 August 2020, Miss Beaumont failed to correctly programme equipment for Intravenous medication.

Therefore, the panel found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether Miss Beaumont'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 a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, Miss Beaumont's fitness to practise is currently impaired as a result of that lack of competence.

Submissions on lack of competence

The NMC has defined a lack of competence as:

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

Ms Stevenson referred the panel to a number of legal cases:

> *Sadler v General Medical Council [2003] UKPC 59*
> *Holton v GMC [2006] EWHC 2960 (Admin)*
> *Calhaem v GMC [2007] EWHC 2006 (Admin)*

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

Ms Stevenson identified the relevant standards where she submitted that Miss Beaumont's actions amounted to a lack of competence and breached the Code.

Ms Stevenson submitted that lack of competence needs to be assessed using a three stage process:

- Is there evidence that Miss Beaumont was made aware of the issues around her competence?
- Is there evidence that she was given the opportunity to improve?
- Is there evidence of further assessment?

Ms Stevenson submitted that the facts found proved show that Miss Beaumont's competence at the time was below the standard expected of a Band 5 registered nurse.

Ms Stevenson submitted that there are a wide-ranging set of errors that have occurred over a long period of time and even when Miss Beaumont was supervised. In particular, there have been repeated concerns surrounding medication administration and management of medications. She submitted that the errors were serious, in particular when patients are not receiving medication which has been prescribed.

Ms Stevenson further submitted that, as a consequence of Miss Beaumont's lack of competence, patients in her care could have been exposed to an unwarranted risk of harm if she were not supervised. Whilst there appears not to have been any physical or mental harm to patients Miss Beaumont was being supervised and so the risk of harm remains were she to practise unrestricted.

Ms Stevenson highlighted that, although some of the charges were more serious than others, overall, the concerns raised relate to fundamental aspects of nursing practice, are wide ranging, occurred on more than one occasion and took place over a long period of time.

Ms Stevenson referred the panel to Ms 2's comments, that there were other newly qualified nurses on the ward, who also had a supernumerary period with an experienced nurse for a couple of weeks and then they would be deemed competent enough to work unsupervised. When asked about the fact that other newly qualified nurses took 2 weeks before they were deemed competent and Miss Beaumont was supervised for 18 months. Ms 2 explained that she has never been in a situation where supervision is needed for so long, it's usually 2-4 weeks.

Ms Stevenson submitted that there is a clear concern with clinical practice. There remains lack of competence, despite Miss Beaumont's efforts and willingness.

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

Submissions on impairment

Ms Stevenson moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and that of *Cohen v General Medical Council [2008] EWHC 581 (Admin).*

Ms Stevenson submitted that Miss Beaumont is impaired because the level of competency demonstrated by her falls far below the standards expected and required of a professional nurse.

Ms Stevenson submitted that Miss Beaumont could have in the past put a patient or patients at unwarranted risk of harm. Miss Beaumont's repeated failings occurred whilst supervised and over a long period of time, even when the long periods of absence are taken into account. Whilst there appears not to have been any physical or mental harm to patients she was being supervised and if she were to practise unrestricted or without supervision, she is liable in the future to put a patient or patients at unwarranted risk of harm.

Ms Stevenson submitted that the failings of Miss Beaumont as found proved plainly bring the profession into disrepute.

Ms Stevenson submitted that Miss Beaumont is no longer engaged with the NMC process. Whilst she has responded to the concerns, it is submitted that there is no evidence before the panel as to insight.

Ms Stevenson submitted that although Miss Beaumont's practice has been restricted, there is also no evidence of any steps having been taken to strengthen her practice, such as training courses or a reflection addressing past failings. There is no insight or explanation as to Miss Beaumont's failings or how she would act differently in the future. As such, the NMC are not reassured that she will not repeat conduct of a similar nature.

In light of the above submissions, Ms Stevenson submitted that there is very limited evidence that were she to continue to practise unrestricted, Miss Beaumont would not be at risk of repeating this behaviour.

Decision and reasons on lack of competence

The panel accepted the advice of the legal assessor.

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

> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> *3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life*
>
> *6.2 maintain the knowledge and skills you need for safe and effective practice*
>
> *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*
>
> *9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*
>
> *10 Keep clear and accurate records relevant to your practice*
>
> *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

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.
16.3 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

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse.

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;
18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines.

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice;
20 Uphold the reputation of your profession at all times.

The panel bore in mind, when reaching its decision, that Miss Beaumont should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

The panel determined that there are wide ranging issues that occurred over a long period of time, which arose whilst Miss Beaumont was under supervision and many of these issues were near misses. The panel highlighted that the majority of the issues of concern related to fundamental nursing competencies that Miss Beaumont failed to understand or carry out.

The panel took into account that although Miss Beaumont was working on a very busy acute ward, she appeared to have been given good support. The panel noted from Ms 1's witness statement that Miss Beaumont had been provided with a mentor and preceptorship to support her from the outset. She had been put on various courses to aid her development including medicines management courses and an Intermediate Life Support course (ILS) to improve her skills with deteriorating patients.

[PRIVATE]

The panel noted that Miss Beaumont had failed her placement whilst she was a student nurse on the same ward, but that she was adamant she wanted her first job as a qualified nurse to be on this busy acute ward. The panel considered that the supervision of Miss Beaumont had been undertaken in a supportive manner, it noted that positive feedback was given when warranted, particularly in relation to her caring nature. The panel noted that once Miss Beaumont started having issues on the ward there had been some discussion of a possible move of her to a less acute ward but that this had not proved possible.

The panel determined that of the 80 charges found proved, a substantial proportion were serious. Examples of particularly serious incidents that occurred include the following:

Charge 1(a) and (b)

This charge involved incorrect dilution of an intravenous drug that could potentially have caused permanent damage to a blood vessel.

Charge 3(d)(i-iii)

These charges relate to a patient whose condition was changing. Lack of prompt action for a deteriorating patient can have very serious or life-changing consequences.

Charge 3n

The failure to recognise the correct route of administration for a drug is extremely serious and potentially catastrophic.

Charge 4(c)(i)

The failure to prioritise a patient who had chest pains which were potentially life-threatening symptoms, and could have had disastrous consequences.

Charge 4f(iv)

Failure to carry out adequate checks on a patient. She ‘popped her head round the door… but hadn’t actually checked’. He was later found deceased. This seriously compromised the opportunity to provide appropriate care, dignity and compassion to a patient and his family at the end of his life.

Charge 4f(v) and (vi)

Miss Beaumont neither checked the blood sugar of a diabetic patient nor gave him his insulin before breakfast, meaning his blood sugar may have been inadequately controlled.

Charge 4f (ix)

Removed the wrong medication patch from a patient thus denying him pain relief for many hours.

Charge 4i(i)

Omitted to handover vital information concerning a patient who should have been a top priority.

Charge 4l(i – v)

These charges involved failures to escalate, to promptly administer medication that would have relieved acute symptoms, and to ensure effective monitoring of a tachycardic patient, with potentially serious consequences.

Charge 4p(ii)

This failure caused a delay in easing a patient's condition at the end of life and enable a dignified end to his life.

Charge 4p(x) and (xi)

This charge involved a failure to action a vital assessment tool and to take adequate action for a deteriorating patient with respiratory problems.
In contrast, when taken in isolation, charges such as 3k(v) (concerning correct coding for TED stockings) and 4o(iv) (checking a wristband prior to giving medication) are not as serious, but coupled with the sheer volume of issues, did amount to a lack of competence.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that notwithstanding that there were some positive comments about Miss Beaumont's caring nature, her practice overall was far below the standard that one would expect of the average registered nurse acting in Miss Beaumont's role.

In all the circumstances, the panel determined that Miss Beaumont's performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Miss Beaumont'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. Patients and their families must be able to trust nurses with their

lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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

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

d) …'

The panel found that Miss Beaumont's patients were put at risk and could have suffered physical and emotional harm as a result of her lack of competence. Miss Beaumont's lack of competence had breached the fundamental tenets of the nursing profession and therefore brought the reputation of the profession into disrepute. The panel therefore considered that limbs a-c of the Dame Janet Smith test are engaged.

Regarding insight, the panel considered that Miss Beaumont has not demonstrated any understanding of how her actions put patients at a risk of harm, nor has she demonstrated any understanding of the implications of her actions or omissions, and how they impacted negatively on the reputation of the nursing profession.

In its consideration of whether Miss Beaumont has taken steps to strengthen her practice, the panel determined that Miss Beaumont has not provided any information to suggest that she has done further training to strengthen her practice.

The panel noted the character reference dated two years ago but was of the view that the referee was personally linked to Miss Beaumont, was not a registered nurse or doctor and was not directly supervising her. He therefore would not have had any profession objective understanding of the concerns raised against her.

The panel is of the view that there is a risk of repetition based on the lack of insight and any attempts to strengthen her practice. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that, in this case involving wide ranging and extensive serious failings, a finding of impairment on public interest grounds was required.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Miss Beaumont's registration has been suspended.

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

Submissions on sanction

Ms Stevenson submitted that the NMC's sanction bid is a 9 month suspension order with a review.

Ms Stevenson submitted that Miss Beaumont's repeated failings fell short of what would be expected of a registered nurse in the circumstances.

Ms Stevenson submitted that as a consequence of Miss Beaumont's lack of competence, patients in her care could have been exposed to an unwarranted risk of harm if she were not supervised. Whilst there appears not to have been any physical or mental harm to patients Miss Beaumont was being supervised and so the risk of harm remains.

Ms Stevenson submitted that although some of the charges were more serious than others, overall, the concerns raised relate to the fundamental aspects of nursing practice, are wide ranging, serious, and occurred on more than one occasion.

Ms Stevenson highlighted that there are also potential attitudinal concerns in this case.

Ms Stevenson also submitted a number of aggravating and mitigating features.

Decision and reasons on sanction

The panel accepted the advice of the legal assessor.

Having found Miss Beaumont'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:

- Wide ranging failures and concerns despite additional support provided.
- Errors occurred over a long period of time, even when taking into account the periods of absence.
- Many serious concerns including medication errors.
- Patients were put at risk and could have suffered physical and emotional harm as a result of her lack of competence.
- Failures and concerns relating to the fundamental aspects of nursing practice.

The panel also took into account the following mitigating features:

- Miss Beaumont was in her first role as a full-time registered nurse.
- [PRIVATE]
- [PRIVATE]
- The working environment was acute and deemed not appropriate for her.

[PRIVATE]

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 Beaumont's practice would not be appropriate in the circumstances. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case.

The panel noted that Miss Beaumont had been on an extended period of supervision and despite this the errors continued to occur. The panel considered that the need for constant supervision put additional stress on busy nursing staff and this approach had been ineffective in improving her practice. The panel noted that Miss Beaumont did not, during her time on the ward, appear to respond to the training she was given. She continued to make basic errors despite attending additional training such as the ILS course.

[PRIVATE]

Furthermore, the panel concluded that the placing of conditions on Miss Beaumont's registration would not adequately address the seriousness of this case and would not protect the public.

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.*

As this is a lack of competence case, the panel had no power to consider a striking-off order at this stage. Such an order can only be considered after a registrant has been subject to a substantive order of conditions of practice or suspension order for at least two years.

Balancing all these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the charges found proved, and to allow Miss Beaumont time to reflect on her errors and to develop insight into her failings. This will also give her the opportunity to obtain alternative work in a healthcare setting if she wishes to do so.

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

Any future panel reviewing this case would be assisted by:

- A structured and detailed reflective piece to demonstrate insight.
- Evidence of maintaining nursing skills and knowledge.
- Evidence of working in a healthcare environment.
- Testimonials from colleagues particularly those from a healthcare setting.
- Miss Beaumont's engagement with the NMC and her attendance at the next review hearing.

This will be confirmed to Miss Beaumont in writing.

Interim order

As the suspension 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 Beaumont's own interests until the suspension 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 Stevenson. She submitted that an interim suspension for 18 months is appropriate to cover the appeal period, on the grounds of public protection and public interest.

Decision and reasons on interim order

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the

facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.