Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
17 – 21 April 2023

Virtual Hearing

Name of registrant:	**Crystal Ann Hards**
NMC PIN:	91C1297E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 1 June 2001
Relevant Location:	East Sussex
Type of case:	Misconduct
Panel members:	Dale Simon (Chair, Lay member) Jim Blair (Registrant member) Caroline Taylor (Lay member)
Legal Assessor:	Juliet Gibbon
Hearings Coordinator:	Jumu Ahmed
Nursing and Midwifery Council:	Represented by Hazel McGuinness, Case Presenter
Mrs Hards:	Not present and not represented
No case to answer:	Charge 2
Facts proved:	Charges 1(a), 1(b), 1(c), 1(d), 3(a), 3(b), 3(c), 4, 5(a), 5(b), 5(c), 5(d), 5(e), 6(a), 6(b), 7
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Hards was not in attendance and that the Notice of Hearing letter had been sent to Mrs Hards' registered address by recorded delivery and by first class post on 14 March 2023.

The panel had regard to the Royal Mail printout which confirmed that the Notice of Hearing was sent by the NMC to Mrs Hards' registered address on 14 March 2023.

Ms McGuinness, 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).

Ms McGuinness informed the panel that the NMC Case Coordinator emailed Mrs Hards on 9 March 2023:

> *'Dear Ms Hards,*
>
> *Good afternoon, I hope you are keeping well.*
>
> *Could you please let me know if you plan on attending your hearing on Monday 17 April 2023 to Friday 21 April 2023?'*

Mrs Hards responded to this email on the same day:

> '*Dear* [Case Coordinator] *vi will not be attending. Thanks Crystal'* [sic]

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 venue of the hearing and, amongst other things, information about Mrs

Hards' 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 Mrs Hards 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 Mrs Hards

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

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 Mrs Hards. In reaching this decision, the panel has considered the submissions of Ms McGuinness, the email from Mrs Hards' dated 9 March 2023, and accepted 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 Mrs Hards;
- Mrs Hards has informed the NMC on 9 March 2023 that she will not be attending the hearing;

- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses have attended today to give live evidence, another witness is due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The panel has Mrs Hards reflective piece dated November 2021 which does not take issue with the substantive facts in this case;
- The charges relate to events that occurred in 2021;
- 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 Mrs Hards in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Hards' decision 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, appropriate and proportionate to proceed in the absence of Mrs Hards. The panel will draw no adverse inference from Mrs Hards' absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms McGuinness, on behalf of the NMC, to amend the wording of the preamble, charge 3a and charge 7. The proposed amendments were to amend the typographical errors which would reflect the evidence and provide clarity.

That you, **a** registered nurse:

…

3. On 9 September 2021:
   a. incorrectly administered Zopiclone to Resident C when they were prescribed ~~Oycodone~~ **Oxycodone**

…

7. Your actions as set out in charges 4, 5 and 6b were dishonest in that you sought to mislead your employer that Colleague A was present when administering and/or auditing controlled drugs **when** she was not.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that the proposed amendments were in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Hards 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 charge (as amended)

That you, a registered nurse:

1. On 27 May 2021, did not administer the following medications to Resident A:
   a. Velanfaxine **[PROVED]**
   b. Donepezil **[PROVED]**
   c. Lantanoprost **[PROVED]**
   d. Lactulose **[PROVED]**

2. On 10 August 2021, administered 0.6mg Glycopyrronium Bromide to Resident B when the correct dose was 0.4mg **[NO CASE TO ANSWER]**

3. On 9 September 2021:

a. incorrectly administered Zopiclone to Resident C when they were prescribed Oxycodone **[PROVED]**

b. did not follow the correct procedures for the administration of medication to Resident C **[PROVED]**

c. did not administer Zopiclone to Resident D **[PROVED]**

4. On 6 October 2021, signed Colleague A's name in the Controlled Drugs ('CD') book to indicate that Colleague A had witnessed you administer medication to Resident E when she had not. **[PROVED]**

5. On 7 October 2021, signed Colleague A's name in the CD book to indicate she had witnessed you administer medication in respect of the following residents when she had not:
   a. Oxycodone 10mg tablets to Resident C; **[PROVED]**
   b. Oxycodone 5mg oral solution to Resident C; **[PROVED]**
   c. Oxycodone Hydrochloride to Resident G; **[PROVED]**
   d. Morphine Sulphate to Resident G; **[PROVED]**

e. Buprenorphine to Resident H. **[PROVED]**

6. On 7 October 2021,
   a. did not follow the correct procedures for administering medication to the residents as set out in charge 5 above. **[PROVED]**
   b. signed Colleague A's name in the CD book to indicate that she acted as a second checker in counting the CD stock and it was "checked and correct". **[PROVED]**

7. Your actions as set out in charges 4, 5 and 6b were dishonest in that you sought to mislead your employer that Colleague A was present when administering and/or auditing controlled drugs when she was not. **[PROVED]**

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

Background

Mrs Hards was referred to the NMC on 19 October 2021 when she had been employed as a registered wellness nurse at Sunrise Senior Living Care Home ('the Home)' for a period of six months. Mrs Hards received a two-week induction which covered manual handling training, fire and medication training and OPUS medication training with supervised medication rounds.

Whilst working at the Home, Mrs Hards made a number of medication errors between 27 May 2021 and 7 October 2021.

It is alleged on 27 May 2021, Resident A, [PRIVATE], did not receive the medications set out in charge 1:

- Venlafaxine [PRIVATE]
- Donepezil [PRIVATE]
- Latanoprost [PRIVATE]
- Lactulose [PRIVATE]

An incident report was raised in relation to this matter. As Mrs Hards was new to the Home's medication rounds, the Home decided that this incident occurred due to lack of concentration on her part.

On 10 August 2021, it is alleged that Mrs Hards administered Glycopyrronium bromide 0.6mg (used for secretion control) to Resident B. However, the correct dose was 0.4mg. When Mrs Hards realised her error, she immediately highlighted this to her line manager. Mrs Hards said that this had occurred due to human error and lack of concentration as she

had been looking at the drug instruction chart for syringe drivers' rather than PRN injections.

On 9 September 2021, it is alleged that Mrs Hards administered Zopiclone [PRIVATE] to Resident C instead of their prescribed Oxycodone [PRIVATE] whist having a second checker. On this occasion, it is alleged that Mrs Hards failed to follow the Home's correct controlled drug ('CD') administration procedures. Additionally, she failed to administer Zopiclone to Resident D.

These errors were dealt with internally. Mrs Hards was asked to retake practical/medication training and was supervised during medication rounds.

On 6 October 2021, Mrs Hards allegedly forged Colleague A's signature in a controlled drug book in order to falsely demonstrate that she had had a second checker when she was administering medication to Resident E when she had not.

On 7 October 2021, Mrs Hards allegedly forged Colleague A's signature in a controlled drug book in order to demonstrate that she had had a second checker when she had not. This was in relation to the medications:

- Oxycodone 10mg tablets, Resident C
- Oxycodone 5mg oral solution, Resident C
- Oxycodone Hydrochloride, Resident G
- Buprenorphine, Resident H
- Morphine Sulphate, Resident G

Additionally, she signed as Colleague A in the controlled drugs book to show that her count of the Home's controlled drug stock was *'checked and correct'*. Mrs Hards, therefore, failed to follow the correct procedures.

On 7 October 2021, Mrs Hards allegedly forged the signature of Colleague A in the controlled drugs book to show that she had administered controlled drugs to two separate residents in the presence of Colleague A who was acting as a second checker when this was not the case. Colleague A was not present when the medication was administered.

Further, on 7 October 2021, whilst undertaking a nightly stock check of controlled drugs, Mrs Hards forged the signature of the same care assistant in seven separate entries of the controlled drugs book to show that she had undertaken the checks in the presence of a colleague when this was not the case.

Following the allegations in October 2021, the Home decided to commence disciplinary proceedings and conducted a local investigation into this matter. During this, Mrs Hards allegedly admitted to forging Colleague A's signature on 7 October 2021. However, Mrs Hards resigned from the Home with immediate effect before the disciplinary process could be completed. Mrs Hards, in her reflective piece to the NMC, did admit to forging Colleague A's signature on 6 October 2021.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC. The documentary evidence included two reflective statements by Mrs Hards made at the time of the incidents and a reflective essay dated November 2021 submitted by her to the NMC.

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 McGuinness on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mrs Hards.

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:

- Witness 1: Clinical Services Manager at Signature Senior Living Home;
- Colleague A: Care Assistant at Signature Senior Living Home.

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

Ms McGuinness made an application that this case be held partly in private on the basis that proper exploration of Mrs Hards' case involves a third party who is a resident within the Home and is named within the documentation. Ms McGuinness submitted that the name of the resident needs to be clarified, and that it does relate to [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

The legal assessor advised 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.

Having heard that there will be reference to a third party's [PRIVATE], the panel determined to hold part of the hearing in private as and when such issues are raised.

Decision and reasons on facts continued

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

- Witness 3: Assisted Living Coordinator at Signature Senior Living Home and Mrs Hards' line manager.

Decision and reasons on application to admit paragraph 9 of Witness 1's written statement and documentary evidence (NW07) as hearsay evidence

The panel heard an application made by Ms McGuinness under Rule 31 to allow paragraph 9 of Witness 1's written statement as hearsay evidence. She provided the panel with a written statement:

> *'6. Rule 31(1) of the Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 provides that: upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings.*
>
> *7. The starting point in relation to the admissibility of evidence in general, therefore, are the requirements of relevance and fairness.*

8. The principles in relation to 'admitting the statements of absent witnesses', and hearsay, are set out at paragraph 45 of Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin):

8.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.

8.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.

8.3. The existence, or otherwise, of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.

8.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.

The NMC's position is that paragraph of [Witness 1] *should be admitted and considered because it is relevant and fair. Further, any specific aspects which are considered to be hearsay should be admitted because any unfairness to the Registrant can be mitigated by the Panel attaching appropriate weight to the evidence.*

"Paragraphs 9

10 August 2021

Crystal was working alongside another Nurse [Ms 4] *to administer Glycopyrronium to a was receiving end of life treatment.* […] *The MAR Chart as written by* [Ms 4] *states 0.4mg was administered which is the correct dose, however after giving the dose Crystal realised that she had administered 0.6mg, she immediately highlighted this to line Manager* [Ms 5]*, Crystal stated this was human error and lack of concentration as she had been looking at the drug instruction chart for syringe driver use rather than PRN injection. There was no patient harm. Crystal's line Manager* [Ms 5] *performed a supervision with her; she was clearly remorseful."*

Accepted that the evidence from [Witness 1] *is the sole and decisive evidence which the Panel can rely on to prove charge 2.*

The evidence as set out in her statement at paragraph 9 is hearsay evidence as the evidence she gives about the incident is not direct evidence. She found out about the incident from and did not speak directly to the Registrant.

She advised in her oral evidence that she had not spoken to Ms Hards directly about the incident and the information she did receive came from a discussion and/or from the incident report form which is not part of the evidence.

Submitted that the evidence comes from a credible and reliable source.

The evidence can be said to contain statements, not in the formal sense, from Line Manager [Ms 5] *who speaks to Ms Hards making the disclosure of the error and gives and explanation.* [Ms 4] *who completed the MAR chart.*

You the Panel should consider in line with Throenycroft [sic] *whether there is of a good and cogent reason for the non-attendance of the witness and this is an important factor however, the absence of a good reason does not automatically result in the exclusion of the evidence.* [Ms 5] *and* [Ms 4] *have not been approached by the NMC for witness statements and have not been requested to attend the hearing on the basis that from the wording of the witness statement it was thought that the witness* [Witness 1] *could provide direct evidence, when clarified during her evidence it is clear she did not speak directly to Ms Hards and that her evidence was hearsay.*

Considering fairness to the Registrant- submit that the Registrant has not objected to the statement or challenged the evidence.'

Ms McGuiness submitted that the NMC does not invite the panel to obtain statements from Ms 5 as it would be disproportionate. She invited the panel to admit the written evidence of Witness 1 in relation to charge 2 on the basis that it is hearsay evidence.

The panel heard and accepted the advice of the legal assessor on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. Further, the panel was referred to the cases of: *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), *Nursing and Midwifery Council v Ogbonna* [2010] EWCA Civ 1216, *R (Bonhoeffer) v GMC* [2011] EWHC 1585 (Admin) and *El Karout v Nursing And Midwifery Council* [2019] EWHC 28 (ADMIN).

The panel first considered whether it would be relevant and fair to admit paragraph 9 of Witness 1's witness statement as hearsay evidence. The panel was of the view that the report was relevant as it speaks directly to charge 2. However, the panel was also of the view that this evidence was the sole and decisive evidence for charge 2 and that it was clear from the statement of Witness 1 that they had always acted in an investigative role to

determine the local case against Mrs Hards rather than being a direct witness. Therefore, the NMC's explanation for not calling Ms 5 as a witness was rejected.

The panel concluded that Mrs Hards would be disadvantaged by the admission of paragraph 9 of Witness 1's statement as hearsay testimony into evidence. The panel determined that it would not be fair to draw the inference that Mrs Hards, an unrepresented registrant, accepted charge 2 simply because she had not formally challenged the charge. The panel, therefore, determined that it would not be fair to admit paragraph 9 of Witness 1's statement as hearsay evidence and as such concluded that the evidence failed to meet the admissibility test.

The panel was also of the view that the documentary evidence produced by Witness 1 (NW07) does not assist the panel as it only demonstrated the dose that the resident should have received, not the dose that was given. The panel also did not have a Medicines Error and Near Miss Report form as evidence.

The panel agreed with the NMC that it would not be proportionate, at this stage, to adjourn the proceedings, in order for evidence in respect of charge 2 to be obtained.

In these circumstances, the panel refused the application.

Decision and reasons on application of no case to answer in respect of charge 2

The panel considered an application from Ms McGuinness that there is no case to answer in respect of charge 2. This application was made under Rule 24(7).

In relation to this application, Ms McGuinness submitted that as the panel had rejected the hearsay application to admit paragraph 9 of Witness 1's written statement and documentary evidence, the NMC was making an application to offer no evidence in respect of charge 2. She referred the panel to the NMC's guidance on *'Offering no*

evidence' (DMA-3). In these circumstances, it was submitted that this charge should not be allowed to remain before the panel.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor. The panel was referred to the NMC's guidance on *'Offering no evidence'* (DMA-3) and the case of *PSA v NMC & X* [2018] EWHC 70 (Admin).

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether Mrs Hards had a case to answer.

The panel was of the view that there was no evidence before it in respect of charge 2 and therefore there was no realistic prospect that it would find the facts of charge 2 proved.

The panel, therefore, granted the NMC's application to offer no evidence in respect of charge 2.

Decision and reasons on application to amend the charge

Ms McGuinness made an application to amend the wording of charges 5(a) and 5(b).

The proposed amendment was to provide clarity on the identity of the Resident C and accurately reflect the evidence.

5. On 7 October 2021, signed Colleague A's name in the CD book to indicate she had witnessed you administer medication in respect of the following residents when she had not
    a. Oxycodone 10mg tablets to Resident ~~F~~ **C**
    b. Oxycodone 5mg oral solution to Resident ~~F~~ **C**

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

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

Decision and reasons on facts continued

The panel noted the written submissions of the NMC and accepted the advice of the legal assessor.

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

Charge 1(a) – (d)

That you, a registered nurse:

1. On 27 May 2021, did not administer the following medications to Resident A:
    a. Velanfaxine
    b. Donepezil
    c. Lantanoprost
    d. Lactulose

These charges are found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Witness 1 and Witness 3. The panel also took into account Mrs Hards reflective piece.

The panel noted from Witness 1's witness statement:

> *'5. At 19.00,* [Resident A] […] *did not receive the following medications; Venlafaxine* […]*, Donepezil* […]*, Latanoprost* […] *and Lactulose* […]*. An incident report was raised by Crystal's Line Manager* [Witness 3] *who addressed this with her. This incident was treated as a lack of concentration on Crystal's part given her being new to the medication round. She was spoken to in a one to one meeting and given support* […]'

The panel noted that Witness 1 was a third party as she was investigating this concern.

The panel took into account Witness 3's witness statement:

> *'5. On 27 May 2021, following the medication round,* [Ms 6] *(Team Member) informed me that Crystal had failed to administer the following medications to Resident A Venlafaxine, Donepezil, Latanoprost and Lactulose.*
>
> *6. Upon becoming aware of the drug errors, I checked to see if Resident A was well and determined that there was no patient harm caused on this occasion. I then spoke to Crystal about her errors and offered support. As Crystal was new and this was Crystal's first medication error, no further training needs were identified.*
>
> *7. An incident form was completed and Crystal completed a reflection saying 'will check my med after the round for any miss and I will ask the nurse to check for any missing signature.'*

During Witness 3's oral evidence, she told the panel that she spoke to Mrs Hards about this concern, and Mrs Hards admitted that she did not administer the four medications to Resident A. Witness 3 had then put remedial measures in place for this concern to not be repeated again.

Mrs Hards did not address this concern in her reflective piece to the NMC.

The panel did not have documentary evidence such as an error report or a MAR chart. However, Witness 3 had given clear and consistent evidence in her statement and oral evidence to the effect that Mrs Hards had admitted to her that she did not administer the four medications for Resident A.

The panel determined, that on the balance of probabilities, it is more likely than not that Mrs Hards did not administer velanfaxine, donepezil, lantanoprost and lactulose to Resident A. The panel, therefore, finds charge 1 proved entirely.

Charge 3(a)

3. On 9 September 2021:

a. incorrectly administered Zopiclone to Resident C when they were prescribed Oxycodone

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Witness 1 and Witness 3. The supplementary documentation included the *'MEDICINES ERROR AND NEAR MISS REPORT FORM'* for Resident C and Resident D. The panel also took into account Mrs Hards' reflective piece.

In Witness 1's witness statement, she wrote:

> *'10. Crystal administered Zopiclone to* [Resident C] *instead of Oxycodone as prescribed* […] *Oxycodone is used as pain relief and Zopiclone is a tablet to help with sleeping. The risk of missing this medication is an increased risk of falling and a potential allergy. However, there was no ill effect. An incident report form was*

completed by the registrant's manager [Witness 3] […]. *I spoke with* [Witness 3] *and asked her to complete a reflection with Crystal, Crystal wrote a reflection. There was no patient harm. Crystal did not follow correct procedure for administration of control drugs, this is procedure is, two trained team members, count, administer and document the medication together witnessing that the correct medication has been given to the correct person, both team members must attend the residents room to witness and confirm the medication has been taken by the resident to whom it is prescribed. This is standard practise and the expectation is that all Registered Nurses are aware of and follow this procedure. Crystal was up to date with her training and had signed to confirm that she had read and understood the Medication Policy. Following this Crystal was asked to retake her practical training and be supervised during drug rounds to demonstrate good practise.*

11. In the linked incident as above Crystal was supposed to administer Zopiclone to [Resident D] […] *It meant that missed his medication. Again, there was no patient harm. As a result of this, following this incident I asked her manager to complete a supervised drug round with her and for Crystal to retake medication training. I produce the accident/incident form that was completed and medicines error/near miss report form* […]'

In Witness 3's live evidence, she told the panel that Resident C was given Resident D's medication, Zopiclone, by Mrs Hards when she should have been given Oxycodone. She also told the panel that she discussed the incident with Mrs Hards and she accepted her mistake.

In Witness 3's witness statement, she stated:

'8. On 9 September 2021, Crystal did not follow the instructions of administered medication for [Resident F] *and gave the wrong medication to the wrong patient.* [Ms 7] *completed an incident form with the drug error. No harm was caused to the resident.*

9. Following this, I completed a near miss report form, which has been exhibited by [Witness 1] […]'

10. Upon becoming aware of the errors, I asked Crystal to complete a reflection. In this she said she will concentrate more in the future.'

The panel had sight of the '*medicines error and near miss report form'* in respect of Resident C and Resident D. It noted that Resident C was not administered Oxycodone and in respect of Resident D, it stated that *'on check and correct we found that Zopiclone was administered to another Resident'.*

Witness 3 confirmed to the panel that Mrs Hards acknowledged that she had administered the wrong medication to Resident C during her conversation with Mrs Hards. However, the panel did not have sight of the incident report form for this incident.

The panel also took into account Mrs Hards local reflective piece which was produced by Witness 1 at the request of the panel. It stated:

'I understand that I gave the wrong drug to the wrong resident […] *This incident has highlighted my need for vigilance at all times I am aware not to be complacent with drug administration I will always concentrate more on my practise.'* [sic]

The panel noted that Mrs Hards local reflective piece, which was submitted by Witness 1, did not specify the resident and what should have been done. However, it was of the view that the chances of the reflective piece referring to a different incident on 9 September 2021 was unlikely.

The panel was of the view that Witness 3 gave clear and consistent evidence and that Mrs Hards had accepted this charge in her local reflective piece, which was produced by Witness 1 at the request of the panel. The panel, therefore, determined, that on the

balance of probabilities, it is more likely than not that Mrs Hards incorrectly administered Zopiclone to Resident C when they were prescribed Oxycodone. The panel, therefore, finds charge 3(a) proved.

Charge 3(b)

3. On 9 September 2021:
b. did not follow the correct procedures for the administration of medication to Resident C

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary, supplementary and oral evidence of Witness 1 and Witness 3. The supplementary documentation included the Homes 'Medication Policy', the MAR chart for Resident B and the *'MEDICINES ERROR AND NEAR MISS REPORT FORM'* for Resident C. The panel also took into account Mrs Hards' reflective piece.

The panel noted paragraphs 10 and 11 of Witness 1's witness statement (as above in charge 3(a)). It was satisfied that as Mrs Hards had given the wrong medication, that in itself demonstrated that she did not follow the correct procedure when administering medication to Resident C. It noted that Ms Hards had signed an agreement to abide by the medication policy on 23 April 2021 and was therefore aware of what the correct procedure is when administering controlled drugs to residents.

Witness 3 told the panel in her oral evidence that she asked Mrs Hards to always have a witness with her to check the administration of the medication. By administering medication to the wrong resident, the panel was of the view that Mrs Hards did not follow the correct procedure as set out within the medication policy to ensure that Resident C was given the correct medication.

The panel had sight of the *'MEDICINES ERROR AND NEAR MISS REPORT FORM'* for Resident C which was completed by Witness 3 and Mrs Hards. It noted that under paragraph 5, it stated:

> *'5. How can this incident be prevented in the future?*
> *Sign the medication only after given, count correctly by both nurse and witnessed nurse, sign the mar chart only after giving the medication*
>
> - *To count medication properly and to be given to resident with an witness around'*

The panel, therefore, determined, that on the balance of probabilities, it is more likely than not that Mrs Hards did not follow the correct procedures for the administration of medication to Resident C. The panel, therefore, finds charge 3(b) proved.

Charge 3(c)

3. On 9 September 2021:
c. did not administer Zopiclone to Resident D

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary, supplementary and the oral evidence of Witness 1 and Witness 3. The supplementary documentation included the *'MEDICINES ERROR AND NEAR MISS REPORT FORM'* for Resident D. The panel also took into account Mrs Hards' reflective statements in respect of this incident.

The panel had sight of the *'MEDICINES ERROR AND NEAR MISS REPORT FORM'* for Resident D which was completed by Witness 3 and Mrs Hards. The panel noted that Zopiclone was given to another resident. It also noted that under paragraph 4, it stated:

‘4. Action taken as a result of the error (e.g. GP called, hospitalised) or near miss To discuss with Crystal about drug error. I asked the witness if the meds was given to resident. [Witness 2] *said that she was with Crystal when they counted meds but* [Witness 2] *did not count the meds or she did not check the name of the resident.’*

Witness 3 confirmed this to the panel during her oral evidence.

The panel was satisfied that Mrs Hards was the registered nurse administering this medication or Resident D. The panel, therefore, determined, that on the balance of probabilities, it is more likely than not that Mrs Hards did not administer Zopiclone to Resident D. The panel, therefore, finds charge 3(c) proved.

Charge 4

4. On 6 October 2021, signed Colleague A’s name in the Controlled Drugs (‘CD’) book to indicate that Colleague A had witnessed you administer medication to Resident E when she had not.

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary, supplementary and the oral evidence of Witness 1 and Colleague A. The supplementary documentation included the work rota for the week of 6 October 2021, Colleague A’s local statement and the controlled drug book entry for Resident E. The panel also took into account Mrs Hards’ local statement dated 10 October 2021.

Witness 1, in her witness statement, wrote:

‘16. I understand that there was also an incident on 06 October 2021 where it was alleged that Crystal signed as [Colleague A] *to witness a drug administration for* [Resident E] *a day where* [Colleague A] *was not at work* […] *Crystal was not*

questioned about this during the local investigation as I could not find any evidence until after she had left. Crystal had been working on 06 October 2021. We know it was Crystal who had forged the signatures as she was the nurse who was working on the Assisted Living Unit this night and because she has signed her signature.'

The panel had sight of the work rota for 6 October 2021 which confirmed that Colleague A was not working a shift that day.

In Colleague A's witness statement, she wrote:

'7. When looking through the controlled drug book, I noted that there was another made under my name that was not signed by myself. This was recorded on the night shift on 06 October 2021, a day where I was not in work myself […]'

Colleague A was clear in her oral evidence that she did not sign the controlled drug book, and confirmed to the panel that the signature was not her signature. She said that the counter signature was that of Mrs Hards.

In Mrs Hards' local statement dated 10 October 2021, she wrote:

'On the 6th October 2021 at 20.40pm I gave xxxxxxxx controlled drugs and returned to the CD cupboard and signed that I had done so.

[Colleague A] *was the carer on the duty at the time who I asked to co-sign, but she was very busy putting people to bed/dealing with her other duties.*

In the morning I noticed she had not returned to co-sign the CD book, which I was aware she was intending to do. I then realised she had gone home so I thought I would write her name for her. I realise this was the not the ethical procedure but I knew, that as the RN, that I had given the drugs and had signed for them as given.

A co-signature was required and I am sure she had every intention of doing so, but I saw the empty space and thought to avoid any issue I would simply write her name as I know the drugs were given as I had administered them and signed as necessary.

I was at the end of a 12.5 hour shift, I know this is no excuse but I was disheartened to see the empty space so I simply wrote her name.

I know the drugs were administered as I had given them and signed for them.

Crystal Hards
10th October 2021'

In light of the above, the panel determined, that on the balance of probabilities, it is more likely than not that Mrs Hards signed Colleague A's name in the controlled drugs book to indicate that Colleague A had witnessed her administer medication to Resident E when she had not. The panel, therefore, finds charge 3(d) proved.

Charge 5(a) – (e)

5. On 7 October 2021, signed Colleague A's name in the CD book to indicate she had witnessed you administer medication in respect of the following residents when she had not:
    a. Oxycodone 10mg tablets to Resident C
    b. Oxycodone 5mg oral solution to Resident C
    c. Oxycodone Hydrochloride to Resident G
    d. Morphine Sulphate to Resident G
    e. Buprenorphine to Resident H

These charges are found proved.

In reaching this decision, the panel took into account all of the documentary, supplementary and the oral evidence of Witness 1 and Colleague A. The supplementary documentation included the work rota for the week of 6 October 2021, Colleague A's local statement and the controlled drug book entry for Resident C, G and H. The panel also took into account Mrs Hards' reflective piece to the NMC.

Witness 1, in her witness statement, wrote:

> *'12. On the 08 October 2021,* [Colleague A], *a carer reported to me that Crystal had forged her signature on the previous night shift (07 October 2021). There were two nurses on duty, one of which was Crystal and the other was* [Ms 8] *and six carers.*
>
> *13. Crystal administered Oxycodone 10mg tablets to* [Resident C], *but did not get the carer to witness the administration as she should have. Instead, she signed* [Colleague A] *in the witness signature box. She also signed as* [Colleague A] *to state that* [Colleague A] had counted the stock and it was "checked and correct". She did the same for the same resident in relation to Oxycodone 5mg oral solution. Crystal signed as [Colleague A] *stating that she had witnessed the checking of stock.*
> […]
>
> *15.* […] *I conducted a local investigation into this, where she admitted to forging her signature on the 07 October 2021. I found that due to her admission the allegations were upheld and Crystal was suspended from medications with immediate effect, she left and did not return to work, resigning thereafter via email* […]'

The panel also took into account Colleague A's witness statement:

> *'4.* […] *I worked the night shift and I can recall that I asked the registrant if she would like me to check the controlled drugs, with her to which she replied that "it*

was done". I presumed she asked one of my colleagues to assist her with her checks.

5. The next night, I was working a night shift again with my colleague [Ms 9]. *To confirm it was the 08th October 2021.* [Ms 9] *asked me to check the controlled drugs with her, which is where I noticed that there was an entry in the controlled drugs book that had been signed as* [Colleague A]. *This was signed for the night previously, which was the 7th October 2021. I can confirm that was not my signature. I had not signed for it. I told* [Ms 9] *that I had not signed any of the entries. She reported it and then I reported the incident to* [Witness 1], *the deputy manager the next morning on the 09 Oct 2021.*

6. […] *For Resident C there are two copies of the controlled drug book, one for Oxycodone 10mg tablets and one for Oxycodone oral solution, which have apparently been signed by myself. The signatures that were not written by myself are clearly indicated on the controlled drug book. For the resident the book was "signed" at 21:10.'*

The panel had sight of the controlled drug book entries for Resident C, G and H in which Colleague A's signature was counter signed.

The panel also took into account Mrs Hards' reflective piece to the NMC:

'[…] *None of this is an excuse for signing the CD book for a carer but* [PRIVATE] *and I was already looking for another job. I also accept the allegation that I signed the carer signature. And further I apologise and recognise my […] understand that even though I felt* [PRIVATE] *I should not have signed the CD book myself. I will take the responsibility for my actions and I want to impress upon everybody that it will never happen again* […]'

In light of the above, the panel determined, that on the balance of probabilities, it is more likely than not that Mrs Hards signed Colleague A's name in the controlled drugs book to

indicate that Colleague A had witnessed her administer medications for Residents C, G and H when she had not. The panel, therefore, finds charge 5 proved in its entirety.

Charge 6(a) and (b)

6. On 7 October 2021,
    a. did not follow the correct procedures for administering medication to the residents as set out in charge 5 above.
    b. Signed Colleague A's name in the CD book to indicate that she acted as a second checker in counting the CD stock and it was "checked and correct"

These charges are found proved.

In reaching this decision, the panel took into account the same evidence for charge 5.

The panel determined, that on the balance of probabilities, it is more likely than not that Mrs Hards did not follow the correct procedures for administering medication to the Residents C, G and H as she had signed Colleague A's name in the CD book to indicate Colleague A had witnessed her administer medication for these residents when she had not and had signed Colleague A's name in the CD book to indicate that she acted as a second checker in counting the CD stock and it was "checked and correct. The panel, therefore, finds charge 6 proved in its entirety.

Charge 7

5. Your actions as set out in charges 4, 5 and 6b were dishonest in that you sought to mislead your employer that Colleague A was present when administering and/or auditing controlled drugs when she was not.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's documentary and oral evidence and Mrs Hards' local reflective statements and the reflective essay that she sent to the NMC.

In considering whether Mrs Hards' actions were dishonest, the panel had regard to the test as set out in the case of *Ivey v Genting Casinos* [2017] UKSC 67:

- *What was the defendant's actual state of knowledge or belief as to the facts; and*
- *Was his conduct dishonest by the standards of ordinary decent people?*

The panel took into account the NMC Guidance document 'Making decisions on dishonesty charges.'

The panel noted from Mrs Hards' Reflective Essay November 2021:

> 'O*n the morning in question there was only 1 signature and the carer had gone home.* [PRIVATE]*. I felt I would get in less trouble but how so wrong was I. I know that this was wrong and improper for a trained nurse.'*

Further, in Mrs Hards' Local Statement dated 10 October 2021, she wrote:

> *'A co-signature was required and I am sure she had every intention of doing so, but I saw the empty space and thought to avoid any issue I would simply write her name as I know the drugs were given as I had administered them and singed as necessary*.'

In considering whether Mrs Hards' conduct would be regarded as dishonest by the standards of 'ordinary decent people', the panel bore in mind her state of mind at the time of this incident. The panel considered that the starting point in its deliberations was that Mrs Hards would have been aware that Colleague A was not a witness to the

administration of the medications in charges 4, 5 and 6. Therefore, the panel was in no doubt that Mrs Hards knew that it was wrong to sign Colleague A's name as having witnessed the administration of medication and acted as a second checker in the controlled drug book for the residents when she had not.

The panel was of the view that Mrs Hards knew that a second checker was required to be present when administering and checking controlled drugs and a second signature was required. She therefore knew that the procedure must be followed. The panel noted that Mrs Hards reflective essay states that she signed to avoid any issue and that she signed as she felt she would get in less trouble. The panel was of the view that these statements were indicative of her state of mind and intention to deliberately mislead her employer into believing that Colleague A was present and counter signed when she was not and had not. The panel determined that this behaviour would be regarded as dishonest by the standards of ordinary decent people in accordance with the test set out in *Ivey*. The panel therefore found Mrs Hards' actions at charges 4, 5 and 6 to be dishonest. This charge is therefore found proved.

Fitness to practise

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

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

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

Submissions on misconduct

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

The panel took into account the written submissions of the NMC:

> *'6. The NMC submit that Ms Hards' misconduct is serious and falls far short of what is expected of a registered nurse. The misconduct is a serious departure from expected standards and risks causing harm to the public and bringing the nursing*

profession into disrepute. Nurses occupy a position of privilege and trust in society and are expected at all times to be professional.

7. The NMC submit Ms Hards' conduct did fall significantly short of the standards expected of a registered nurse when she failed to administer medication to Resident A , incorrectly administer to Resident C the medication for Resident D, did not follow the correct procedures for administration of medication, signed Colleague A's name in the Control Drugs book to indicate that she had witnessed Colleague A administer medication when she had not and was dishonest when she sought to mislead her employer that Colleague A was present when she was administering and/or auditing controlled drugs when she was not and amounted to multiple breaches of the Code. Specifically:

Practise effectively

You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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

Preserve safety

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

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

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

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

Promote professionalism and trust

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

8. Breaches of the code do not automatically amount to a finding of misconduct however submit that the facts found proved are sufficiently serious and consequently should be marked as such.

9. The Panel should have regard to R (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin) who stated that misconduct must be 'sufficiently serious that it can properly be described as misconduct going to fitness to practise'.

10. The NMC submit that the misconduct in this case is "sufficiently serious", that it can be properly described as misconduct.

11. In all the circumstances, it is submitted that the Registrant's conduct falls far below the standards which would be considered acceptable and that the facts found proved amount to misconduct.'

Submissions on impairment

Ms McGuinness 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).

The panel took into account the written submissions of the NMC:

> *'19. In this case, it is submitted that all limbs are engaged.*
>
> ***Public Protection***
>
> ***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***
>
> […]
>
> *25. The NMC submit that Ms Hards has acted in the past and/or is liable so as to put Residents at unwarranted risk of harm.*
>
> *26. Resident A did not receive medications and while no patient harm occurred in this case, not giving patients medication could result in patient harm in the future.*
>
> *27. Resident C was administered Zopiclone instead of their Oxycodone and while their was no patient harm the risk of missing medication is an increased risk of falling or a potential allergy in being given a medication which was not prescribed. The risk in not following procedure for administration of controlled drugs it that as occurred in this case the wrong medication being given to the wrong patient, or the wrong amount of medication being given to a patient/resident.*

28. Resident D, there is a potential for harm in that the resident was not given their medication however no harm was caused.

29. It is submitted that there is a potential for harm when Ms Hards did not follow the correct procedure in relation to Resident C, H and G when she signed as [Colleague A] *when* [Colleague A] *was not present. As set out above there is a potential for harm in that errors can be made in relation to administering the wrong medication or the wrong amount of medication.*

30. There is a reasonable expectation that nurses act with honesty and integrity. Ms Hards in signing Colleague A's name in the CD book when she knew Colleague A had not witnessed the administering of medication or acted as a second checker where she sought to mislead her employer that Colleague A was present when she was not breached that trust.

31. 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 loved ones lives. When considering the risk of harm to patients, should consider the possible consequences of the concerns, such as members of the public feeling reluctant to access health and care services. Especially in circumstances where a resident or patients are vulnerable.

32. They must make sure that their conduct at all times justifies their patients' and public's trust in the profession.

33. If the public may not feel able to trust nurses, members of the public might take risks with their own health and wellbeing by avoiding treatment or care from nurses, midwives, or nursing associates.

Public Interest

Has in the past brought and/or is liable in the future to bring the medical profession into disrepute

34. Registered professionals occupy a position of trust in society to be responsible for the care of residents or patients. Ms Hards by her own admission at local level signed on 7 occasions Colleague A's name in the CD book to indicate that she had witnessed the administration and checking of control drug when she had not and further that she was dishonest as she sought to mislead her employer that Colleague A was present when she was not.

35. The NMC submit that such behaviour not only brought Ms Hards' reputation into disrepute, but also that of the wider profession. This in turn undermined the public's confidence in the profession as a whole.

36. The public, quite rightly, expect nurses to provide safe and effective care, keep clear and accurate records and act with honesty and integrity at all times. The facts, as set out in the charges, brought the profession into disrepute and had the potential to undermine trust and confidence in the profession.

37. Ms Hards' conduct has brought the profession into disrepute. Confidence in the profession would be undermined if its regulator took no action.

Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession

38. The Code divides its guidance for nurses in to four categories which can be considered as representative of the fundamental principles of nursing care. These are:

a)Prioritise people;
b)Practice effectively;

c)Preserve safety and
d)Promote professionalism and trust

39. It is submitted that the NMC have set out above, how, by identifying the relevant sections of the Code, Ms Hards has breached fundamental tenets of the profession. These sections of the Code define, in particular, the responsibility to practise effectively, preserve safety and promote professionalism and trust.

Has in the past acted dishonestly and/or is liable to act dishonestly in the future

40. Ms Hards acted dishonestly in that she sought to mislead her employer that Colleague A was present when administering and/or auditing controlled drugs when she was not. Furthermore, this occurred on 7 occasions.

Remediation, reflection, training, insight and remorse.

41. It is submitted that Silber J's guidance on remediation is also of assistance; that when deciding whether fitness to practise is impaired panels should take account of:

- *Whether the conduct which led to the charge is easily remediable;*
- *Whether it has been remedied; and*
- *Whether it is likely to be repeated.*

42. The first question is whether the concerns can be addressed. That is, are there steps that the nurse, midwife or nursing associate can take to address the identified problem in their practice?

43. It can often be very difficult, if not impossible, to put right the outcome of the clinical failing or behaviour, especially where it has resulted in harm to a patient. However, rather than focusing on whether the outcome can be put right, the Panel should assess the conduct that led to the outcome, and consider whether the

conduct itself, and the risks it could pose, can be addressed by taking steps, such as completing training courses or supervised practice.

44. The NMC submit that while the clinical concerns/conduct at charges 1 and 3 is capable of remediation. The concerns at charges 5, 6 and 7 are serious concerns which are more difficult to put right. The NMC direct the Panel to NMC Guidance at FtP-3a, in that she falsified records and acted dishonesty on more than one occasion.

45. Before effective steps can be taken to remedy the concerns, the nurse must recognise the problem that needs to be addressed, and particularly demonstrate sufficient insight.

46. […]

47. It is a matter for the Panel's own judgment on whether and to what extent the Registrant has demonstrated insight, and on what significance to attach in this case to the presence or lack of insight, to whatever degree you find it is demonstrated.

48. […]

Insight

49. A nurse, midwife or nursing associate who shows insight will usually be able to: step back from the situation and look at it objectively, recognise what went wrong, accept their role and responsibilities and how they are relevant to what happened, appreciate what could and should have been done differently and understand how to act differently in the future to avoid similar problems happening.

50. Draw the Panel's attention to guidance at Reference: FTP-13b where it states that:

[…]

51. The NMC submit that this is a case where Ms Hards has demonstrated some insight by way of her acceptance at local level.

52. Submit that Ms Hards has shown some insight the concerns and into her own failings. She has explained in her reflective pieces she recognised what went wrong, what she would do in the future in relation to the procedure for CDs and at local level she advised she had to concentrate more.

53. However common practice which Ms Hards highlights in her reflections was disputed by both [Witness 1] *and* [Colleague A]*.*

54. The NMC submit that her insight is lacking Ms Hards does not fully recognise or address the impact on the profession, she does not address the potential harm to patients her conduct could cause when she does not follow the correct or procedure or the impact on her Colleagues.

55. Ms Hards as provided a training certificate in relation to Medication Training for Care dated 6 November 2011 and a testimonial.

56. Turning finally to remorse, witness [Witness 1] *describes that she was remorseful at local level and in her reflective piece November 2021 she apologises and speaks of great shame and guilt.*

57. The NMC submit that it cannot be said that is highly unlikely that the conduct will be repeated as her insight requires to be developed around the direct impact on patients and colleagues.

58. In all the circumstances, it is submitted that the misconduct has not been remediated and a finding of current impairment needs to be proved in order to

sufficiently protect the public, maintain the confidence in the NMC as a regulator and uphold the standard of the profession generally.

Public interest

59. […]

60. […]

61. […]

62. …]

63. […] *The NMC submit that this is a case which does fall into the category of serious concerns as the misconduct relates to falsifying documentation in circumstances where procedure for controlled drugs has not been followed on numerous occasions and the Registrant has acted dishonestly.*

64. The public interest calls for a finding of impairment to maintain trust and confidence in the profession and its regulator. A well-informed member of the public would be concerned/shocked to find that Ms Hards was not found to be impaired given the nature and circumstances of the charge.

65. Baring all factors in mind, it is my submission that the concerns have not been remediated, and I would therefore ask you to find Ms Hards' fitness to practise currently impaired by reason of her misconduct.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Remedy UK Ltd, R (on the application of) v General Medical Council* [2010] EWHC 1245 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Grant.*

Decision and reasons on misconduct

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

The panel was of the view that Mrs Hards' actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Hards' actions amounted to a breach of the Code. Specifically:

> *'**10 Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
>
> *To achieve this, you must:*
>
> *10.1 - complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
>
> *10.3 – complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
>
> ***18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations***
>
> *To achieve this, you must:*

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

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

To achieve this, you must:

19.1 - take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It had regard to the case of *Roylance v General Medical Council* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

The panel determined that Mrs Hards' actions in charges 1 and 3, if taken individually, would not necessarily amount to misconduct. However, in taking all of the charges together, the panel determined that Mrs Hards' actions and her dishonesty fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct. It was of the view that Mrs Hards' actions amounted to a course of conduct that demonstrated an unwillingness to follow procedure and policy, which is indicative of an attitudinal issue. The panel was of the view that Mrs Hards was a registered nurse who would have known that she should follow the rules and procedures in the Home when administering medication. Further, it was of the view that Mrs Hards would definitely have known that she should not falsify a counter signature in the controlled drugs book. The panel was also of the view that in not following the rules and procedures in administering medication, residents were exposed to a potential risk of significant harm. The panel determined that Mrs Hards' failed to prioritise people and the safety of residents, which is a requirement of her as a registered nurse.

The panel was of the view that Mrs Hards' failure to comply with the policies of safe administration of medication extended over a period of time. It also believed that her intention to mislead the Home when falsifying Colleague A's counter signature could be indicative of a deep seated attitudinal issue. Further, it determined that Mrs Hards' dishonesty breached fundamental tenets of the Code. The panel was also of the view that Mrs Hards' conduct was very serious.

The panel, therefore, concluded that Mrs Hards' conduct and dishonest behaviour fell significantly short of the standards expected of a registered nurse and is sufficiently serious to amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct found proved, Mrs Hards' fitness to practise is currently impaired.

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

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

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

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

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

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

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

The panel concluded that all four limbs of this test were engaged.

Whilst there is no evidence to suggest that Mrs Hards' actions caused actual harm to the residents, her failure to follow the policy when administering medication and dishonesty put residents at risk of significant harm. Furthermore, having breached multiple provisions of the Code, the panel determined that Mrs Hards' misconduct, in particular her dishonesty, had breached fundamental tenets of the nursing profession and had therefore brought its reputation into disrepute. It was of the view that as Mrs Hards did not follow the process of administering medication, errors were made which could have resulted in a lack of trust by the residents and their families. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find Mrs Hards' fitness to practise to be impaired as the charges relating to dishonesty are extremely serious.

The panel took into account Mrs Hards' reflective pieces and her reflective essay and testimonial dated November 2021. The panel noted that Mrs Hards had demonstrated remorse for some incidents and had stated that she regretted her decision to falsify Colleague A's signature. However, the panel was of the view that Mrs Hards' had on occasion sought to deflect responsibility for her actions by suggesting that she was acting in accordance with local practice and that she had asked Colleague A to counter sign the controlled drug book on a day when Colleague A was not on duty. She had also failed to address the impact of her actions on patients, colleagues, the wider profession or the public as a whole. The panel therefore determined that Mrs Hards had demonstrated limited insight.

Further, the panel noted that Mrs Hards testimonial and 'Medication Training for Care' certificate were both dated November 2021. Therefore the panel had no information before it to assist it in understanding whether Mrs Hards had strengthened her practice or developed her limited insight during the intervening period.

Therefore, the panel was of the view that Mrs Hards had not demonstrated sufficient insight into her misconduct. The panel could not be satisfied, in the absence of any evidence, that Mrs Hards understands and appreciates the seriousness of her failure to act appropriately and her dishonesty.

The panel was of the view that Mrs Hards actions to mislead the Home by counter signing Colleague A's signature was an attitudinal concern. It was of the view that in Mrs Hard stating '*I was at the end of a 12.5 hour shift, I know this is no excuse but I was disheartened to see the empty space so I simply wrote her name*' demonstrates that Mrs Hards lacks insight or any understanding of her conduct.

In considering whether Mrs Hards had remediated her nursing practice, the panel was of the view that the concerns raised in charge 1 and 3 were capable of remediation. It bore in mind that dishonesty is often more difficult to remediate than clinical concerns. However, apart from the certificate in 'Medication Training for Care' dated 6 November 2021, the panel did not have any further relevant training and/or other information before it addressing any steps Mrs Hards has taken to strengthen her practice.

Therefore, in having regard to the above, the panel considered there to be insufficient evidence to demonstrate that Mrs Hards had remediated her misconduct. The panel was of the view that Mrs Hards has not demonstrated that she has a level of insight into the concerns identified. The panel also did not have any evidence to allay its concerns that Mrs Hards may currently pose a risk to patient safety. In the absence of any evidence to the contrary, it considered there to be a risk of repetition of Mrs Hards' dishonesty and a risk of unwarranted harm to patients in her care, should adequate safeguards not be

imposed on her nursing practice. Therefore, the panel 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 considered there to be a public interest in the circumstances of this case. The panel found that the charges found proved are serious and includes dishonesty. It was of the view that a fully informed member of the public would be concerned by its findings on facts and misconduct. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mrs Hards' fitness to practise as a registered nurse is currently impaired on the grounds of public protection and public interest.

Sanction

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

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

Submissions on sanction

Ms McGuinness provided the panel with written submissions:

'6. The aggravating features of this case have been identified as follows:

- *Conduct which could patients at the risk of suffering harm*
- *Limited insight.*
- *Deep seated personality and/or attitudinal concerns.*
- *Repeated conduct*
- *Dishonesty directly linked to clinical practice*

7. The mitigating features of this case have been identified as follows:

- *Admissions at an early stage at local level*
- *Remorse*

8. The NMC invite the Panel to assess the available sanctions and suggest you should do so in ascending order, considering the least restrictive first:

Taking no action

9. Taking no action or a caution order - The NMC's guidance (SAN-3a and SAN-2b) states that it will be rare to take no action where there is a finding of current impairment and this is not one of those rare cases. The seriousness of the misconduct means that taking no action would not be appropriate. Given the determination that Ms Hards is impaired on both public protection and public interest grounds and that there remains a risk of repetition and a risk of harm to patients Taking no further action would neither be appropriate or proportionate.

Caution Order

10. A caution order would also not be in the public interest nor mark the seriousness and would be insufficient to maintain high standards within the profession or the trust the public place in the profession. The NMC sanction guidance (SAN 3-B) states that a caution order may be appropriate where 'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'

11. Ms Hards' case is not at the lower end of the spectrum and a caution order would be inappropriate in view of the seriousness of the case.

12. Ms Hards has been found to be impaired on both public protection and public interest grounds and you the panel determined that she has not yet remediated her misconduct and that due to this there is a risk of repetition and a risk of harm to patients. It would not be appropriate sanction given as there has been an identified risk to the public.

Conditions of Practice Order

13. A conditions of practice order ('COPO') is ordinarily imposed where the concerns relate to clinical practice. A COPO may be appropriate to address the concerns relating to charges 1 and 3 however a COPO would not be appropriate in respect of the concerns in charges 4, 5, 6 and 7.

14. […]

15. The misconduct and the concerns behind the misconduct are capable of being indicative of harmful, deep- seated, personality or attitudinal concerns. The fact that some of the allegations relate to dishonesty, seriously aggravates the situation. The dishonest conduct happened on more than one occasion in relation to more than one resident, related directly to her clinical practice and could have put patients at risk of harm. Conditions are particularly difficult to formulate in cases which involve dishonesty. A conditions of practice order would not reflect the seriousness of the concerns raised or maintain public confidence. A COPO would not address the public interest.

Suspension Order

16. […]

17. […]

18. The Guidance reflects that the main difference between the appropriateness of a suspension order and a striking-off order involves an assessment of whether Ms Hards' misconduct is fundamentally incompatible with her continued presence on the register.

19. […]

20. Considering the SG the NMC submit that Ms Hards dishonest conduct is directly related to her clinical practice where there was a direct risk to patients, her conduct could not be described as a one off incident and neither spontaneous or opportunistic as the conduct happened or more than one occasion. The NMC submit that Ms Hards on 6 October 2021 entered [Colleague A] *when Colleague A*

was not working and then repeated the conduct again in the same way, the next day in respect of more than one resident.

21. Further, Ms Hards although did engage at local level and provided a reflective piece in November 2021 which do demonstrate remorse, she has not engaged in the hearing and as only demonstrated limited insight. The NMC submit that in the Panel's determination was of the view:

> *"that Mrs Hards' had on occasion sought to deflect responsibility for her actions by suggesting that she was acting in accordance with local practice and that she had asked Colleague A to counter sign the controlled drug book on a day when Colleague A was not on duty. She had also failed to address the impact of her actions on patients, colleagues, the wider profession or the public as a whole. The panel therefore determined that Mrs Hards had demonstrated limited insight".*

22. The NMC submit that taking into account the guidance and factors set out above, an order for suspension is neither appropriate or proportionate.

Striking- Off Order

23. […]

24. […]

25. In warranting its submission to impose a striking-off order, the NMC highlight the fundamental concerns regarding the Ms Hards' trustworthiness as a registered professional and that her conduct is fundamentally incompatible with continued registration. A striking-off order is the appropriate and proportionate sanction in this case.

26. An order for Strike-Off is the only order that will meet the public interest of maintaining public confidence in the profession and upholding proper professional standards by declaring that the registrant's behaviour was unacceptable for a registered professional.'

Decision and reasons on sanction

Having found Mrs Hards' 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:

- Conduct which could have placed residents at the risk of suffering harm
- Attitudinal concerns due to repetition of poor practice and falsification of records
- Repeated poor conduct which fell below the expectations of a registered nurse
- Dishonesty directly linked to clinical practice

The panel also took into account the following mitigating features:

- Admissions at an early stage at local level
- Remorse
- In reflective essay, Mrs Hards suggested that she was unhappy in the work environment

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.

The panel 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 Mrs Hards' practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Hards' misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Hards' registration would be a sufficient and appropriate response. The panel is of the view that although a conditions of practice order can usually address medication administration concerns, Mrs Hards conduct in failing on numerous occasions to follow policy and procedure when administering medication demonstrated attitudinal concerns which coupled with the findings of dishonesty made this case unsuitable for the imposition of a conditions of practice order. The panel determined that the misconduct and dishonesty identified in this case was not something that can be addressed through retraining and concluded that there are no practical or workable conditions that could be formulated given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on Mrs Hards' 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 panel had regard to the SG which outlines the circumstances where a suspension order may be appropriate. The panel considered that Mrs Hards had demonstrated attitudinal issues as she had repeatedly disregarded the policy and

procedure in medication administration and had falsified Colleague A's signature in the controlled drug book. Further, Mrs Hards had only demonstrated limited insight and had not provided evidence of any further insight or any steps she had taken to strengthen her practice regarding her failings since November 2021.

The panel was of the view that Mrs Mrs Hards' conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. It noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Hards' actions is fundamentally incompatible with her remaining on the register and as such, determined that a suspension order would not be a sufficient, appropriate or proportionate sanction in that it would not protect patients or maintain confidence in the nursing profession.

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

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

The panel determined that Mrs Hards' actions and her dishonesty was a significant departure from the standards expected of a registered nurse, and was fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Hards' misconduct was serious, placed residents at risk of harm, and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. Further, the panel was of the view that in allowing Mrs Hards to continue practising would undermine colleagues and other nurses' confidence as a result of the lack of trust.

The panel recognised the adverse effect that a striking off order may have on Mrs Hards but was mindful of case law and of the NMC's own guidance that the reputation of the nursing profession is more important than the fortunes of an individual nurse.

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

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

This will be confirmed to Mrs Hards in writing.

Interim order

As the striking-off 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 Mrs Hards' own interest until the striking-off sanction takes effect.

The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms McGuiness. She submitted that an interim suspension order for a period of 18 months is required for the same reasons as submitted previously and to allow sufficient time for any appeal to be heard.

Decision and reasons on interim order

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

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

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

That concludes this determination.