Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 20 March 2023 – Thursday 23 March 2023
Tuesday 1 August 2023 – Thursday 3 August 2023

Virtual Hearing

Name of registrant:	Stephen Maguithi
NMC PIN:	06H2869E
Part(s) of the register:	Registered Nurse – Sub Part 1 RNA: Adult Nurse – 21 September 2006
Relevant location:	Windsor and Maidenhead
Type of case:	Misconduct
Panel members:	Rachel Cook (Chair, Lay member) Sue Rourke (Registrant member) Jennifer Portway (Lay member)
Legal Assessor:	Timothy Bradbury (20 March – 23 March 2023) Lachlan Wilson (1 August – 3 August 2023)
Hearing Coordinator:	Teige Gardner (20 March – 23 March 2023) Opeyemi Lawal (2 August 2023) Taymika Brandy (1 August and 3 August 2023)
Nursing and Midwifery Council:	Represented by Mary Kyriacou, Case Presenter
Mr Maguithi:	Present but unrepresented
Facts proved by way of admission:	Charges 2(d), 2(e) and 2(f)
Facts found proved:	Charges 1(a), 1(b), 2(a) and 2(g)
Facts not proved:	Charges 1(c), 2(b), 2(c) and 3
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (9 months)**
Interim order:	**Conditions of practice order (18 months)**

Details of charge

“That you, a registered nurse,

1. On a nightshift between 1st and 2nd March 2020;

a. Slept whilst on duty,
b. Did not answer call bells,
c. Did not undertake hourly observations

2. On a nightshift between 2nd and 3rd March 2020;

a. Slept whilst on duty,
b. Did not respond to resident call bells,
c. Did not undertake hourly observations,
d. Left the drugs room unlocked,
e. Left the drugs trolley unlocked,
f. Stored resident medication in pots before the medication was due to be administered,
g. Signed MAR charts of residents to show that required medication had been administered, when it had not been.

3. Your actions as set out in charge 2g were dishonest in that you knew you had not administered the required medication but signed the resident MAR charts to show that it had been administered.

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

Decision and reasons on application to admit hearsay evidence

Having heard oral evidence from Witness 1 and Witness 2, the panel heard an application made by Ms Kyriacou, on behalf of the Nursing and Midwifery Council (NMC), under Rule 31 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).
to allow the written statement of Witness 3 into evidence. She provided written submissions for this application and then proceeded to provide oral submissions.

Ms Kyriacou made reference to the cases of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 Admin and *Al – Khawaja and Tahery V UK* [2011] ECHR 2127 (Grand Chamber) (Al – Khawaja).

Ms Kyriacou submitted that Witness 3 was not present at this hearing and, whilst the NMC had made reasonable efforts to ensure that this witness was present, she was unable to attend proceedings today or at a later date. She submitted that Witness 3 is not the sole or decisive witness for any of the charges, rather she corroborates the evidence of Witness 1.

Ms Kyriacou submitted that there is no unfairness to you if the panel are to accept this application. She submitted that there are no apparent reasons as to why Witness 3 would have fabricated her evidence. She submitted that it is for the panel to decide what weight is given to Witness 3's evidence. Therefore, for the reasons above, she invited the panel to accept this application.

You told the panel that it would be unfair to you if Witness 3's witness statement is accepted into evidence. You informed the panel that, as she would not be in attendance, you do not have the opportunity to cross-examine or test Witness 3's evidence. You invited the panel to not accept this application.

The panel heard and accepted the legal assessor's advice 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.

The panel considered the hearsay application in regard to Witness 3. The panel noted that Witness 3's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by her.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 3 to that of a written statement. The panel determined that Witness 3 is not the sole or decisive witness for any of the charges, rather she corroborates Witness 1's evidence. The panel noted that Witness 1 has given live evidence, which you challenged and has been tested. Further, it noted that you have admitted to two of the charges that Witness 3 speaks to.

The panel noted that Witness 3 provided a statement to their employer, Longlea Nursing Home (the Home) on 3 March 2020, the day after the allegations arose. The panel was of the view that there would have been limited time for Witness 3 to fabricate this statement, the day after the alleged incidents. The panel further noted that the statement, dated 3 March 2020, is consistent with Witness 3's NMC statement.

The panel was of the view that Witness 3's evidence is relevant to the charges, in particular some aspects of Charge 2. The panel therefore determined that Witness 3's evidence is relevant.

The panel then considered if there was a good reason for Witness 3's non-attendance at proceedings today. The panel determined that the NMC had made all reasonable efforts to secure the attendance of Witness 3 as detailed in a chronology provided by the NMC.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 3 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

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

During your oral evidence, you made reference to personal and private matters. Ms Kyriacou made an agreed application that your oral evidence, in its entirety, be held in private on the basis that proper exploration of your oral evidence involves reference to your personal and private life. The application was made pursuant to Rule 19 of the Rules.

You did not oppose this application and indicated your agreement.

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 during your oral evidence on the basis that you may wish to refer to your family and their health during your evidence.

Background

The allegations arose whilst you were working at the Home during two-night shifts between 1 and 2 March 2020 and 2 and 3 March 2020. It is alleged that you had fallen asleep whilst on duty between 1 and 2 March 2020, thereby not undertaking patient observations or responding to call bells. It is alleged that on the next night shift, 2 to 3 March, you again fell asleep, thereby not undertaking patient observations or responding to call bells. It is further alleged that on 2 to 3 March 2020 you left the drugs trolley and drugs room unlocked. You are also alleged to have dishonestly filled in patients Medicines Administration Record (MAR) charts to say they had been given medication when they had not.

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you made admissions to Charges 2(d), 2(e) and 2(f).

The panel therefore finds charges 2(d), 2(e) and 2(f) proved, by way of your admissions.

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 Kyriacou on behalf of the NMC and the submissions made by you.

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

- Witness 1: Home Manager at Longlea Nursing Home (the Home).
- Witness 2: Health Care assistant at the Home.

The panel also heard oral evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, which included reminding the panel of the test for determining dishonesty as set out in the case of *Ivey v Genting Casinos [UK] Ltd* [2017] UKSC 67. It considered the witness and documentary evidence provided by both the NMC and you.

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

Charge 1(a)

"That you, a registered nurse,

1. On a nightshift between 1st and 2nd March 2020;

a. Slept whilst on duty,"

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, in particular the live, written and documentary evidence from Witness 1, the documentary and live evidence of Witness 2 and your evidence.

You deny this charge. The panel noted that you told it you had taken your break between 02:00 and 03:00 on that shift, and at no point did you fall asleep.

The panel first considered if you had an obligation to be awake during your break whilst working on a nightshift. The panel heard evidence from Witness 1 that nurses in the Home were allowed an amalgamated one-hour break over the course of a nightshift, but she would not expect the only registered nurse on duty to sleep whilst on nightshift. Witness 1 described you falling asleep on night duty as a *"dereliction of duty".* The panel determined that no duty has been established that you were required to be awake throughout the entirety of your nightshift. The panel concluded that you were allowed to sleep during your break on a nightshift, as long as this sleep was confined to your amalgamated break hour and that you could be woken if required. Witness 1 told the panel that the Home paid staff for their breaks with an expectation that the staff member would assist if required and then take some extra time later.

Witness 1 in her NMC witness statement states:

> *"On 2 March 2020, [Witness 2] and [Colleague 1] had informed me that the registrant was sleeping on shifts whilst he was meant to be awake on duty. They informed me that he went to sleep on his break and that he slept for quite a long time after his break had finished. They alleged that he wasn't carrying out the hourly checks or responding to any call bells."*

This evidence is corroborated by Witness 2's witness statement, made for the purpose of the Home's internal investigation. This statement is dated 8 March 2020, prepared within days of the events of 1 March 2020 to 2 March 2020. Witness 2 states:

> "*Stephen went to start to do the medication round. Once he had finished these he came to the lounge and said that he was going to have some rest. He started this at 11.45pm. He went to sleep and did not wake up even when the bells were ringing despite us calling him to help. I kept calling him and woke him up at 02.30 to go and answer a bell. He then returned to lounge and went back to sleep and did not wake up until 5.30am.".*

The panel then considered the live evidence of Witness 2. She gave a compelling account of finding you asleep and having to wake you up. When asked how she knew that you were asleep, described you as "*snoring".* The panel determined that Witness 2, in relation to this charge, gave consistent and reliable evidence.

The panel noted that during cross-examination it was put to you that you had been asleep on the night of 1 through to 2 March 2020 from approximately 11.45pm until 5.30am. You confirmed your denial of this particular allegation and explained that there were three people working that night (yourself, Witness 2 and Colleague 1) and that to behave in such a way would have been unfair to the other staff members.

However, Witness 2 told the panel:

'*that night Stephen, very very tired, not a rest all day because of his family. I said once work finished, have a little rest.'*

The panel accepted that Witness 2 had alerted you and asked you to assist her to care for a resident at 2.30am. Witness 2 stated that she '*woke him up at 02.30 to go and answer a bell*'.

The panel concluded that, whilst you were allowed to sleep on nightshift during your hour-long break, you had slept outside of your hour-long break. The panel noted that you had started your break at 11:45, you woke up to help Witness 2 at around 02:30, then you went back to sleep in the lounge until approximately 5.30am. Therefore, you had been asleep for longer than your one-hour break. Considering the evidence of Witness 2, particularly her near contemporaneous statement that she provided to the Home, the panel found that you slept whilst on duty on 1 to 2 March 2020.

In light of the above, the panel determined that this charge, on the balance of probabilities, is found proved.

Charge 1(b)

"1. On a nightshift between 1st and 2nd March 2020;

b. Did not answer call bells,"

This charge is found proved.

In reaching this decision, the panel took into account the live evidence and written statement of Witnesses 2 and 1 and your evidence.

You deny this charge.

The panel first considered if you had a duty to answer the call bells in the Home.

The panel took into account the evidence of Witness 1, who said:

> "*Anyone can answer bell […] normally closet person, if it doesn't go off, someone go and investigate. Different sound if needed in an emergency"*.

The panel concluded that there was a joint responsibility from members of staff at the Home to answer call bells, with the practice being that whoever was the nearest and available did so.

Witness 2 also stated within the Home investigation interview that:

> *"He went to sleep and did not wake up even when the bells were ringing despite us calling him to help."*

The panel also noted that, according to Witness 2, a bell rang at 2.30am on 2 March 2020. Witness 2 stated that she answered the bell and alerted you.

The panel considered its findings in Charge 1(a) and determined that, as you had been asleep whilst on nightshift, you could not have answered the call bells. Accordingly, the panel finds this charge is proved on the balance of probabilities.

Charge 1(c)

> *"1. On a nightshift between 1st and 2nd March 2020;*
>
> *c. Did not undertake hourly observations"*

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it, including the care notes, the evidence of Witness 2 and your evidence.

You deny this charge. You informed the panel that you would allocate tasks depending on how busy the nightshift was and that this would not necessarily be written down.

The panel then considered the oral evidence of Witness 2, who informed the panel that "*Maybe that night he was tired. He had been out all day. I leave him. I have a good heart. You can have a rest, I will go if anyone ring the bell".*

Witness 2 further told the panel that you *"did do his hourly checks when it was his turn, he was very tired that night."*

The panel noted, from Witness 2's oral evidence, that there was an agreement between you and Witness 2 that you could rest. Witness 2 told the panel that she was aware of your family problems. The panel also considered the care notes, of Resident A which confirm that you undertook an observation of Resident A at 23.12 and then again at 05.30. However, the panel accepted Witness 2's evidence that Witness 2 had taken responsibility for the resident observations and that Witness 2 would alert you if she needed you to assist. In these circumstances, the panel did not consider there was a duty upon you to undertake hourly observation.

The panel was not satisfied that you had a duty to carry out these hourly observations and accepted that you had allocated this work to Witness 2. Therefore, the panel found this charge not proved.

Charge 2(a)

"2. On a nightshift between 2nd and 3rd March 2020;

a. Slept whilst on duty,"

This charge is found proved.

You deny this charge. In reaching this decision, the panel took into account all the evidence before it, in particular the live, written and documentary evidence from Witness 1, Witness 3's NMC statement and your evidence.

The panel first considered if you had an obligation to be awake during your break whilst working on nightshift. The panel noted its findings in Charge 1(a), and found that you did have a duty to be awake when you were not on your break.

The panel considered what time you had taken your break. During the Home's internal investigation, Witness 3 stated:

> "*At 12.15 Stephen went for his break in the lounge. He sat in a chair with his feet up on another chair and covered himself with a blanket. He was allocated to carry out the hourly checks at 2am which I completed as he had not returned."*

You dispute the claim made by Witness 3 that your break commenced at 12:15. In your written statement you said that:

> "*When the situation was calm (that was about 00.45 AM) I arranged for breaks and I was the first to go i sat in a Conner and i had asked the healthcare assistance to call me if anything happened or i am required. I sat down at the corner i had my earphones on i did not hear* [Witness 1] *come in or see her come in because of the position i sitting i could not see around the corner. And there was no need for me to go around because i had assigned a health care assistance for 2AM round."*

The panel noted that you dispute Witness 3's evidence that your break commenced at 12.15. The panel did not hear oral evidence from Witness 3 and in the absence of being able to test Witness 3's evidence, the panel placed little weight upon Witness 3's evidence that your break commenced at 12.15

The panel then took into consideration the evidence of Witness 1. Witness 1 stated that she arrived at the Home on 3 March 2020 at 1.30am and found you asleep:

"*When I went to the lounge room, I found Stephen sleeping on the chair with his legs up on another chair and covered in a blanket. When I walked in, I walked around him and went into the kitchen to see that everything was safe in there.*"

You told the panel that you were adamant that you were not asleep but that you were listening to an audio book through your headphones. You could not remember if your eyes were open or closed. You confirmed that you were on your hour's break.

The panel found that Witness 1, in her oral evidence, gave a compelling account of finding you asleep. She stated:

"*you were asleep, I went right up to you, moved furniture, tidied, came right up to you, fast asleep, I am [a] nurse, I carried on and looked after the poorly resident.*"

You were adamant that you were not asleep but that you were listening to an audio book through your headphones and you could not remember if your eyes were open or closed. You confirmed that you were on your hour's break.

When it was put to you that 1.30am until 3.05am is longer than an hour, you responded by stating that you continued to sit in the lounge, following your break and explained that: "*No where to sit, all sit in the lounge. I allocate me sit in the lounge. One upstairs. Other one around the corner. That is how we sit. Usually not move unless there is an emergency.*"

The panel found your evidence that there would have been no change in your behaviours from being on a break, to being back on duty, inconsistent with your oral and written evidence. You repeatedly stated that you had been caring for a resident that night who was very unwell.

In your statement, you said as follows:

'*Unfortunately, that night i had a very ill patient i spent with this patient a good amount of hours as he was requiring back to back nebulisers i was with these patient for along time so the night routine changed a little bit. That means as the Nurse in charge that night i had to re allocate the other two staff for hourly rounds, and i concentrated with the ill patient."*

The panel did not accept your evidence that you remained in the lounge awake, with no evident change in your behaviours, following the ending of your break. This is because your evidence to the panel was that this was a very busy nightshift, and you were concerned about a very poorly patient. The panel considered it was more likely than not that you were asleep between approximately 1.30am and 3.05am, albeit that an hour of this period was your break.

Accordingly, the panel found this charge proved.

Charge 2(b)

"2. On a nightshift between 2nd and 3rd March 2020;

b. Did not respond to resident call bells,"

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and your evidence.

The panel first considered if you had a duty to respond to resident call bells. As stated in Charge 1(b), the panel considered that there was a joint responsibility from members of staff to answer call bells, with the practice being that whoever was the nearest and available did so.

The panel then considered the evidence of Witness 1. She stated:

"*I decided not to wake Stephen up and that I would carry out his nursing duties. During the shift, two call bells rang but Stephen was unaware of this."*

The panel noted that Witness 1 does not specify the times of the call bells. In addition, the exact times of your one-hour break are not known. The panel considered that the two call bells heard by Witness 1 could have been rung within your one-hour break. If so, you would not have been under a duty to answer the call bell. The panel established that this duty only arose if you were nearby and available. During your break, you would not have been available and would only have been expected to respond to a call bell during a break if alerted and told that you were required. Further, the panel noted that Witness 1 is clear that she did not wake you.

There is no additional evidence presented to the panel that call bells were rung and that you did not answer them, other than the two call bells referred to by Witness 1.

In summary, the panel was not satisfied that you had a duty to answer the call bells and therefore it finds Charge 2(b) not proved.

Charge 2(c)

"2. On a nightshift between 2nd and 3rd March 2020;

c. Did not undertake hourly observations,"

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it, in particular the evidence of Witnesses 1 and 3, and your evidence.

The panel found limited evidence of your responsibility to undertake hourly observation. It considered the evidence presented by the NMC and found that there is no specific reference to your duty to undertake hourly observations in Witness 1's witness statement. Witness 3 states:

"*Stephen carried out the 11pm checks which he allocated himself to do...He did not complete is 2am check, which I had done for him."*

The panel considered your evidence, you stated:

"*…there was no need for me to go around because i had assigned a health care assistance for 2AM round."*

You reiterated this point during your oral evidence. You disputed that the 02:00 hourly observation was yours to do. The panel did not hear oral evidence from Witness 3 and in the absence of being able to test her evidence, it could only place limited weight upon it. In addition, the panel had not had sight of the relevant allocation charts which may have specified who was to undertake the hourly observations.

The NMC urged the panel to take into account that in communication with the NMC you had ticked a pro-forma box to indicate that you accepted this sub-particular. You told the panel that this was an error and you had misread the box. The panel accepted that this was a genuine error on your part and noted at the start of the hearing you confirmed your denial of Particular 2(c).

Taking into account the lack of evidence to establish that you were under a duty to undertake hourly observation together with the evidence that you had completed the 23:00 observation and allocated the 02:00 observation to Witness 3, the panel found Charge 2(c) not proved.

Charge 2(g)

"2. On a nightshift between 2nd and 3rd March 2020;

g. Signed MAR charts of residents to show that required medication had been administered, when it had not been."

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Witness 1.

The panel determined that you were under a duty to only sign the MAR chart when the medication has been administered, not when the medication has been dispended. Witness 1 told the panel in oral evidence that there was a:

> '*full and robust policy, clearly states – administered directly blister pack to the pot, to the patient in one transference. Cannot pre-pot. Popped blister pack, watch patient swallow and then MAR chart signed'.*

The panel also considered that this practice was in accordance with the NMC code which would have been known to you as an experienced nurse.

Witness 1 states within her statement as follows:

> "*I saw on the chart that all of the resident's medication had been signed for and the 7am check was shown to be already complete."*

The panel also had sight of the MAR chart for two residents only. The panel noted that Resident A's MAR chart clearly showed a signature at 7am on 3 March 2020 which had been struck through with Witness 1's initials above.

You explained to the panel that you had signed the MAR chart to record that the medication had been dispensed but not necessarily administered. You went on to explain that there were occasions when a resident refused their medication or were asleep, and you were therefore unable to administer the dispensed medication. In these circumstances you told the panel that you would sign the MAR chart but would annotate the MAR chart with a letter, above your signature, which recorded that the medication had been dispensed but not administered.

This practice, of signing the MAR chart when dispensing the medication, was put to Witness 1 who confirmed that she undertook medication audits. Witness 1 had never seen this practice (signing the MAR chart and annotating it with a letter) and would have been concerned if she had.

In addition, the panel had sight of the MAR chart covering the four-week period from 10 February until 8 March 2020 and did not note any signatures with a letter annotated above the signature.

Based upon the evidence of Witness 1 and having had sight of the MAR chart, the panel found that you had signed the MAR charts of residents to show that required medication had been administered, when it had not been.

Charge 3

> *"3. Your actions as set out in charge 2g were dishonest in that you knew you had not administered the required medication but signed the resident MAR charts to show that it had been administered."*

This charge is found NOT proved.

The panel first considered your state of mind.

The panel considered your investigation interview with Witness 1 which was undertaken soon after the events of 2 and 3 March 2020. This near contemporaneous meeting note states:

> "*Stephen responded that he was simply trying to save time as he was so tired. I have never done anything like this before and the carers can confirm that | always take the trolley out with me with the blister packs out on the top and take them as I need them."*

The panel also noted, from your written statement, your concern about having enough time within your working shift to complete all the required tasks and care for the patients appropriately. You state:

> *'The manager wanted all the patient to have they breakfast before 8.00 AM and breakfast done by 8.00 am. Thats means there was pressure because most patient they were in bed and most of medication we could not give on empty stomach. That means most patient we had to wake them even earlier that 6.00 AM to give them breakfast so that they can take they medication. These didn't feel right to me as these are Elderly patient that are retired and are slow to do things, and were were only 3 people during the night. I didnt find the place safe for me to work and i didntfeel the place was safe enough forthe residents to be there. The MAR chart that we used originally coming as medication to be given at 08.00 AM but most of them were changed by hand by the manager to 07.00 AM.'*

In oral evidence, you stated that you did not know how things would go during that night shift because of the very poorly patient you were caring for that evening and that you wanted to try to get ahead because you had been '*caught up in a crisis'*.

The panel concluded that you did not intend to mislead when you signed the MAR chart. The panel determined that you had filled out the MAR chart to save time in anticipation that you would be the one to administer the 07:00 medication.

The panel next considered whether, in these circumstances, your actions would be regarded as dishonest by the standards of ordinary decent people. The panel concluded that ordinary decent people would undoubtedly regard your actions to be inappropriate and contrary to good practice. However, in the absence of any intention to mislead, the panel did not conclude that such actions would be regarded as dishonest.

Accordingly, this charge is found not 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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct and impairment

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.'

Ms Kyriacou invited the panel to take the view that your actions amount to a breach of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code"). She then directed the panel to specific paragraphs and standards and identified where, in the NMC's view, your actions amounted to a breach of those standards. She also referred the panel to the relevant cases of *Roylance* and *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin).

Ms Kyriacou submitted that whilst breaches of the Code do not automatically result in a finding of misconduct, your behaviour fell significantly short of the standards expected of a registered nurse. She invited the panel to take the view that the facts found proved amount to misconduct.

She submitted that the facts found proved demonstrate you have not acted as a role model and that your behaviour, at charges 1(a) and 2 (a) particularly, does not demonstrate professional or role model behaviour to which your colleagues should aspire. She submitted that your behaviour was rather to the contrary and your behaviour did not promote safety and care of patients.

Ms Kyriacou submitted that as a result of the above, the misconduct is serious. She submitted that you had a responsibility as the only nurse on duty and that you should have made yourself available for support to ensure the safety of your colleagues and patients at all times whilst not on a break. She submitted that you failed to ensure that patients were properly and appropriately cared for by sleeping outside of your break times.

Ms Kyriacou submitted that on the nightshift between 1 and 2 March 2020, you fell asleep between 23:45 – 05:30, with the exception of being woken at 02:30. She submitted that this was a significant period of time on a 12-hour shift, placing burden and responsibility on your colleagues.

Ms Kyriacou submitted that this fell far below what is expected of you being the only nurse on shift that night. She submitted that this is evident in your failure to answer call bells during the nightshift. She submitted that whilst there was no evidence of actual patient harm as a result of this, you wrongly relied on colleagues to answer call bells, and slept whilst you should have been undertaking care duties.

In relation to charge 2, she submitted that, while you had recognised the necessity to deal with a particularly unwell patient, you remained asleep even beyond your break. You decided to leave the drugs room and drugs trolley unlocked and to dispense

medication hours before the morning drug round. Ms Kyriacou highlighted that you also tasked a colleague with keeping an eye on the unlocked trolley and drug room. She submitted that you did not wake when your break had finished to take care of the unwell patient and to relieve your colleague of your responsibilities.

Ms Kyriacou submitted that you unfairly relied on your colleague to monitor the drugs room. She submitted that the patients were left at a real risk of harm as result of your actions. She submitted that you had fallen asleep with headphones in, and this would have made it more difficult for you to be alerted to a situation requiring your urgent attention. In relation to the drugs trolley and room being unlocked. Ms Kyriacou submitted that it would have been possible for a patient to have accessed the medication and this put patients at a real risk of harm. Whilst you had left a colleague with the unlocked trolley and next to the unlocked room to mitigate this risk, Ms Kyriacou submitted that this was insufficient to mitigate, as that colleague may have needed to leave at any time and that you unreasonably placed responsibility on your colleague.

Ms Kyriacou submitted that in relation to the pre potted medication, a number of things could have gone wrong, such as, a risk of contamination or risk of wrong medication being administered to patients. You told the panel you did this to save time. However, Ms Kyriacou submitted that this was reckless and that you did not weigh up the possible consequences of your actions.

Ms Kyriacou submitted that your actions over these two nights could damage public confidence in the nursing profession and the trust of family members who have loved ones in care homes. She submitted that your actions call into question what level of care patients would receive in the Home. In relation to your actions at charge 2 (g), she submitted that, if there was a change in circumstances for example a patient refused medication, this would result in inaccurate documentation of medication administered.

Ms Kyriacou submitted that on each night, you placed patients at risk of harm and that public confidence in the profession would be undermined if a finding of misconduct was not made.

Ms Kyriacou moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. She submitted that public confidence in the profession would be undermined if a finding of impairment was not made in this case.

Ms Kyriacou referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and submitted that limbs a), b) and c) of Dame Janet Smith's test as set out in the Fifth Report from Shipman were engaged by your past actions and the need to consider whether the relevant professional:

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*

Ms Kyriacou submitted that you in the past acted and/or are liable in the future to act so as to put a patient or patients at unwarranted risk of harm and you did so by sleeping on two shifts, placing responsibility on others to care for your patients, leaving the drug trolley unlocked, pre potting medication and completing MAR charts before the medication had been administered.

Ms Kyriacou submitted that you have in the past brought and/or are liable in the future to bring the medical profession into disrepute. You have not demonstrated insight or an in-depth reflection as to why your actions were wrong. You have no understanding of the risk associated with that practice. There is a real risk that such conduct could be repeated.

She further submitted that you have in the past breached and/or are liable in the future to breach one of the fundamental tenets of the medical profession. Your actions constituted a fundamental breach of professional standards and the fundamental tenets of the profession.

Referring to the case *Cohen v GMC* [2015] EWHC 581 (Admin), Ms Kyriacou invited the panel to consider reflection, evidence of strengthened practice and what relevant training courses you have undertaken. She emphasised that whilst your conduct is remediable it has not been remediated. Even though you have continued to work for some time with no concerns there is no evidence of insight or remorse.

The panel heard evidence from you under oath.

You stated that before the first incident occurred you were at the Home for nearly one year without any incident. You also stated that witness 1 described you as *'knowledgeable, liked by patients and good at handovers'*.

You were however critical of Witness 1 and the manner in which she addressed her concerns about your actions.

When asked to focus on the seriousness of the facts found proved, you repeated your invitation to the panel to consider that Witness 2 and the hearsay evidence was unreliable.

In relation to charge 2(f), you accepted that you made a mistake with pre-potting medication.

You stated that when Witness 1 came to give live evidence, she stated that the medication was securely potted and that Witness 1 gave every single resident their medication. Witness 1 found no error or any evidence to suggest you harmed the patients or intended to cause harm.

You stated that you potted the medication, with the intention to give the medication, a chain had been broken whereby another member of staff gave that medication: "*I knew what medication I had potted Witness 1 did not."*

You told the panel that you were responsible for staff allocations and can change allocations of staff and when they take their breaks, depending on the needs of the patients.

In terms of the unwell patient on 2-3 March 2020, you told the panel that when the patient was stable, you told everyone you were going to go on break and when they needed you, you always responded. You stated that Witness 2 said that you were a good person, always willing to help.

You further told the panel that pre potting medication was done in the interest of time and of the unwell patient. You suggested to the panel that you read an NMC article about whether nurses can have a nap, however, you did not provide the panel with a reference or the name of the article nor did you reveal what the article concluded. You stated that patient care was not compromised.

You reminded the panel that this is a forward-looking exercise. In the future the likelihood for this to happen again is unlikely as there has been no previous incidents. You told the panel that it has been three years since the incident occurred and you have had no further concerns even though you have worked in various placements such as in A&E and a chemotherapy unit.

You told the panel that you enjoy nursing as it is your passion as you enjoy taking care of people. You accept that you made errors, particularly in communicating, and you

remind yourself everyday as a nurse that it is important you communicate with your colleagues. You told the panel that these events happened due to pressures at the time, and you were going through a difficult time in your personal life which you should have communicated to your manager.

At the time of these events, you were working part time at the Home undertaking two consecutive night shifts and you should have telephoned or emailed Witness 1 regarding your personal circumstances. When you are caught in a crisis you can go into a panic and forget that you have someone alongside that can offer help.

Ms Kyriacou asked you some questions which are summarised below:

> ***'If you had communicated, what would you have been asking of your manager?*** *I would have told my manager what I was going through … I would have asked for time off work and any other help that she thought she could offer.'*
>
> ***'On the night of 2-3 March 2020, what would you have done in hindsight?*** *That night I was pressurised and patients needed medication to keep them well. I came to work and found an unwell patient and other patients needed medication. I would have saved the patient's life first, and told the carers to take care of the other patients, if I needed them I would call them. I had prioritised the unwell patient. Having an asthma attack and needed a nebulizer. He was stable so therefore I decided we can take a break*
>
> *… I would have done something differently; I would have contacted my manager.'*
>
> ***'On the night of 2-3 March 2020 if the situation became out of your control, but you considered that the patient was stable and that's why you did not act?*** *I have reflected on this; I would have left the medication there the way it was not trying to catch up with my work that's where mistakes happen. A lot of pressure. In the future I would avoid assumptions.'*

'With reflection can you see a problem with signing MAR charts in advance of medication being administered? *I have changed that practice to avoid confusion'*

Following your oral evidence under oath, Ms Kyriacou made further submissions. She stated that in respect of the first night, you would have communicated to your manager and asked for time off and when asked about the second night, your answer was confusing in that you said you would have contacted your manager if the situation became out of control and needed escalation.

Ms Kyriacou submitted that you have stated that the practice you now adopt in respect of the MAR chart is different. However, what the panel have not heard is an explanation in any depth of what you would have done differently, to manage the crisis the Home was in on 2-3 March 2020, in particular leaving the drug room and drug trolley unlocked. She submitted that there is limited reflection from you.

Ms Kyriacou maintained her submission that you remain impaired and due to limited insight, there is a real risk of repetition and no evidence of strengthened practice and relevant training.

You submitted that after the incidents, there were no further concerns raised against you. You further submitted that you have undertaken mandatory training required by Interact Medical (the Agency), every year to update yourself and prove that you are still competent. You stated that this training needed to be completed to continue to work for the Agency, but you were never provided with certificates but are willing to contact the Agency to obtain confirmation of completion.

You submitted that you wanted to undertake an enhanced drug training course with the Agency but have been unable to undertake it to date. However, you stated that you now take these concerns as a learning point as to how things should be controlled and managed, as well as what to do in the future.

The panel accepted the advice of the legal assessor who reminded the panel of the factors be taken into account when determining misconduct and impairment including the updated NMC guidance as to whether a registrant is deemed capable of practising kindly, safely and professionally without the need for restrictions.

Decision and reasons on misconduct

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

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

> *'8.2 maintain effective communication with colleagues*
> *…*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> *…*
>
> *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*
> *…*
> *18.4 take all steps to keep medicines stored securely*
> *…*
>
> *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'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel went through each of the charges to assess whether your actions amount to misconduct.

Charges 1(a) and 2(a)

The panel determined that your actions were serious misconduct in the context that this behaviour was repeated over two days. The panel noted that on the first occasion during the 1 and 2 March 2020, Witness 2 did encourage you to rest due to your personal circumstances. However, the panel determined that this was serious misconduct due to the length of time you slept which was from 11:45pm until 5:30am albeit Witness 2 did wake you up at 2:30 to answer a bell.

On 2-3 March 2020, you slept whilst on duty having behaved similarly on the previous nightshift, as found proven within charge 1(a). This was therefore not a ‘one off incident’ and on the second occasion you slept whilst leaving the drug room and trolley unlocked and with medication ‘pre potted’. In addition, you slept past your breaktime when you were supposed to be caring for a very ‘poorly’ patient and were the only registered nurse on duty.

The panel determined that, these incidents taken together, amounted to serious misconduct.

Charge 1(b)

The panel took into account the context and determined that your actions did fall below the standard expected but it did not seriously fall below and therefore the panel found no misconduct in relation to this charge.

Charge 2(d) and 2(e)

The panel determined that your actions went against the requirement to keep medication in a safe and locked place. The panel also noted that you placed a burden on a colleague who is not a qualified nurse.

The panel determined that your actions amounted to serious misconduct as there was a potential risk to the 21 residents of the Home.

Charge 2(f) and 2(g)

The panel took into account the context and your reasonings but concluded that you should not have pre-potted medication. The panel determined that this was risk taking behaviour and as an experienced nurse you should have known the risks. The panel determined that your actions were a serious failing in your duty to safely dispense and administer medication. The panel also determined that these risks were compounded by the drugs room being left unlocked. Further, by completing the MAR chart in advance of administering medication you created additional risk, including the potential for wrong medications being given or medication being omitted.

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

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired.

The panel had sight of two references, one from the Agency and a second from a colleague staff nurse, both dated 23 March 2023 and an agency feedback form from the chemotherapy unit dated 31 July 2023. The panel also had sight of the Registrant's response bundle which included a statement from you which drew attention to your length of service as a registered nurse without incident.

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

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

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

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

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

The panel finds that patients were put at risk and there was the potential for physical harm as a result of your misconduct. Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel went on to consider your level of insight.

You told the panel that, with hindsight, you should not have gone to work on 1-2 March 2020 and should not have assumed that the deputy manager had told Witness 1 about your challenging personal circumstances. You also told the panel, in relation to pre-potting the medication and signing the MAR chart, that you would avoid '*trying to catch up'* on the assumption that the medication would be administered.

However, the panel noted that rather than acknowledging your responsibilities in relation to the charges found proved, your focus was upon providing considerable detail about the context within which the misconduct arose. You told the panel about your challenging personal circumstances at the time and the circumstances at the Home on 2-3 March 2020 which included you caring for a very '*poorly patient'*.

The panel concluded that your insight was limited and largely related to you recognising a need to change your style of communication. Within your written response you stated as follows:

> *"I needed to communicate with the manager about my feeling and the care of the patient especially what happens in the morning in longlea nursing home."*

In your oral evidence you told the panel that you remind yourself every day as a nurse of the need to communicate effectively.

The panel did not find your insight to be complete for the following reasons;

1. It was put to you on more than one occasion what you would do differently in a similar situation. Your response was to continue to justify your actions and to minimise your responsibility. You repeatedly referred to the way in which Witness

1 had addressed the concerns, the hearsay evidence that had been admitted and Witness 2 being reluctant to give evidence. In relation to Witness 2, the panel noted that within her statement to the Home, dated 8 March 2020, she raised her professional concerns and concluded: *"I like Stephen and don't want to cause any trouble".* The panel acknowledged that Witness 2 may have been reluctant to cause you difficulties and give evidence, but that did not mean that the evidence she gave was unreliable.

2. In relation to charges surrounding the administering of the medication, you displayed a further lack of insight when you stated that there was no risk to patients because witness 1 was able to administer the pre-potted drugs on 3 March 2020. You told the panel: "*There is no risk or harm that has been identified and* [Witness 1] *gave the same medication with no problems.".* The panel was concerned that you failed to recognise the potential for harm to arise to the 21 Home residents in the context of pre-potted medication within an unlocked drugs room.

3. The panel asked you how a member of the public may view your behaviour. You responded that the public would want to know if actual harm was caused. The panel considered that this further highlighted a failure to acknowledge the risk of harm.

The panel was satisfied that the misconduct in this case is capable of being addressed. The panel considered that your lack of insight may have adversely impacted upon your understanding of the need to undertake specific training to remediate your errors. You stated that because of Covid you had been unable to access relevant training. You were specifically asked whether you had accessed any online training relevant to the charges, namely in relation to record keeping and administering medication. You responded that you had been trying to keep up to date with your revalidation training. You stated that you will undertake additional training in the future and intend to ask your agency about this. The panel therefore concluded that you have not, as yet, fully remediated.

The panel is of the view that there is a risk of repetition. The panel noted the following from your written response: *'Within my 16 years of nursing, this my [sic] only incident that has happened.'* The panel acknowledge that these incidents took place on two dates only, 1-2 and 2-3 March 2020, and that you have worked since and before without incident.

However, the July 2023 feedback report relates to your role as a nurse working within a chemotherapy ward. You told the panel that there are different processes within a chemotherapy ward which included two nurses to administer medication and co-sign. As a result, the panel concluded that external processes may have prevented further incident and that there is a lack of evidence that you, through meaningful reflection and insight, have decided to change your working practices.

Taking into account your limited insight and lack of relevant remediation, the panel considers that a risk of repetition remains and is accordingly not satisfied that you are capable of practising kindly, safely and professionally.

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

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

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has decided to make a conditions of practice order for a period of nine months, with a review before expiry of the order. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and to the NMC's published guidance on sanction ('the SG'). It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Kyriacou submitted that the appropriate sanction in this case is a six-month suspension order with a review before the expiry of the order. Ms Kyriacou referred to the SG and reminded the panel to consider the principle of proportionality. She also stated that any sanction imposed must be proportionate and go no further than is necessary in order to protect the public and uphold the public interest. Ms Kyriacou outlined aggravating and mitigating factors for the panel to consider.

Ms Kyriacou invited the panel to consider the sanctions in ascending order, and to have regard to the public protection and public interest issues in deciding on the most appropriate and proportionate sanction. She then referred to the SG which states:

> *'If a nurse, midwife or nursing associate's actions put people at risk of being harmed, this risk makes their case more serious. However, keeping patients safe also includes avoiding a culture of blame or cover up, so we do not want to punish nurses, midwives or nursing associates for making genuine clinical mistakes.'*

Ms Kyriacou submitted that as the panel have found your misconduct put patients at risk of harm due to you sleeping on a nightshift on two occasions (1-2 and 2-3 March 2020) for a prolonged period of time, this falls into the category of cases that are identified as 'serious'. She then referred to the NMC guidance titled 'Considering sanctions for serious cases' ref SAN-2.

Ms Kyriacou submitted that during the second nightshift on 2-3 March 2020, you had slept whilst leaving the drug room and trolley unlocked, leaving a colleague to keep an eye on this and whilst you knew a patient was very unwell. She submitted that you incorrectly completed a MAR chart and also pre-potted medication hours in advance and unless steps are taken to prevent your misconduct from reoccurring there is a risk of repetition.

Ms Kyriacou submitted that members of the public and the families of those with loved ones in care homes would be concerned by your conduct. She submitted that you have no remorse or understanding of the impact of your actions or how they impacted on patients, colleagues and the wider public.

Ms Kyriacou submitted that the seriousness of this case requires temporary removal from the register and that a period of suspension is sufficient to protect patient and maintain public confidence in the profession and the NMC as its regulator. She submitted that due to your lack of remorse, the panel may consider that it evidences attitudinal issues.

Ms Kyriacou submitted that your insight is limited and has been wavering throughout these proceedings, and that any evidence of your insight was elicited during cross examination. She submitted that only then did you address what you would have done differently and that this was limited to maintaining better communication with your manager. She submitted that you were unable to identify any risks associated with your misconduct.

Ms Kyriacou submitted that taking no action would not address the public protection and public interest issues, and that a caution order would not be appropriate, as this case

did not involve misconduct at the lower end of the spectrum of impaired fitness to practise.

In addressing a conditions of practice order, Ms Kyriacou submitted that this sanction is not appropriate or proportionate as there are no measurable or workable conditions that can be formulated to address you sleeping whilst on duty. She submitted that it is a matter for the panel whether it is able to formulate relevant, proportionate, measurable and workable conditions. She submitted that if the panel are minded to consider a condition of practice order then she would suggest including the following:

- Indirect supervision;
- You must only work for one substantial employer;
- You must Create a Personal Development Plan (PDP), to address medication preparation, administration and record keeping; and
- Regular meetings with your line manager/mentor or supervisor to discuss progress towards achieving the aims set out in your PDP

Ms Kyriacou submitted that your behaviour is not fundamentally incompatible with you remaining on the register, therefore a striking-off order is not proportionate or appropriate.

You submitted that you have said several times during the course of this hearing how remorseful you were for the incidents. You submitted that you have demonstrated for the last three years, through practising unrestricted without incident, that your patients are protected. You also submitted that you have worked in accordance with the Code.

You submitted that the misconduct was a one-off incident in your career and that there has been no repetition of these events before or since. You submitted that taking into account the whole scenario, you have insight, and you understand that when you are on duty you should consider your surroundings including your colleagues and the patients.

You submitted that taken collectively, these events have been a learning point for you and that as you were not restricted from practising since, you have had the chance to prove yourself to the NMC and the community that you are a safe practitioner.

You referred the panel to the references you have provided and submitted that the reference you had requested from your previous employer was written in an open and honest way. You submitted that you would continue to practise safely.

You submitted that you are willing to be subject to supervisory conditions, which could include direct or indirect supervision. You submitted that you are currently working in one hospital and that you can be monitored as you are working within one Trust.

Decision and reasons on sanction

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

The panel considered the following aggravating features in this case:

- Lack of full insight
- Lack of complete remediation
- Your conduct was repeated, albeit not over an extended period of time.

The panel also considered the following mitigating features in this case:

- The context of the misconduct, there being a number of challenging issues in your personal life at home.

- You have been working as a nurse without concern for many years prior to and for three years since these events.
- You made admissions to charges 2(d),(e) and (f) at the outset.

The panel bore in mind the submissions of Ms Kyriacou regarding this case being serious and it concluded that the concerns in this case did not meet the criteria of cases considered as serious, as outlined in the guidance 'Considering sanctions for serious cases' ref SAN-2.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the panel's findings. The panel decided that it would neither protect the public nor be 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 panel's findings including the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.*' The panel considered that your misconduct was not at the lower end of the spectrum of impaired fitness to practise and that a caution order would be insufficient to mark the panel's findings. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be an appropriate and proportionate response. The panel is mindful that any conditions imposed must be appropriate, proportionate, measurable and workable. The panel took into account the SG, which sets out when conditions may be appropriate, and it concluded that the following apply in this case:

- *'no evidence of harmful deep-seated personality or attitudinal problems*

- *identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining*
- *no evidence of general incompetence*
- *potential and willingness to respond positively to retraining*
- *patients will not be put in danger either directly or indirectly as a result of the conditions*
- *the conditions will protect patients during the period they are in force*
- *conditions can be created that can be monitored and assessed.'*

The panel determined that it would be possible to formulate workable and measurable conditions which would address the failings highlighted in this case. The panel acknowledged you have insight, albeit, limited and that these incidents had taken place over two consecutive nightshifts at the Home and there had been no further concerns regarding your practice whilst you have been working unrestricted since 2020. The panel was of the view that the issues identified could be addressed through additional training and supervision. Further the panel noted your engagement with these proceedings and was of the view that you would respond positively to training and supervision. The panel considered that the public would be adequately protected by the imposition of appropriate conditions.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order would be disproportionate and would not be a reasonable response in the circumstances of your case. The panel noted the mitigating factors it had identified. A suspension order would deprive you of the opportunity to evidence safe and effective patient care and would deprive the public of a registered nurse who, but for these matters, may otherwise be a good and conscientious professional. The panel concluded that a suspension order was not necessary or appropriate to meet the public interest in this case.

Having regard to the matters it has identified, the panel concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> *'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.'*

1) You must keep the NMC informed about anywhere you are working by:

> a. Telling your case officer within seven days of accepting or leaving any employment.
>
> b. Giving your case officer your employer's contact details.

2). You must keep the NMC informed about anywhere you are studying by:

> a. Telling your case officer within seven days of accepting any course of study.
>
> b. Giving your case officer the name and contact details of the organisation offering that course of study.

3). You must immediately give a copy of these conditions to:

> a. Any organisation or person you work for.
>
> b. Any agency you apply to or are registered with for work.

c. Any employers you apply to for work (at the time of application).

d. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

e. Any current or prospective patients or clients you intend to see or care for when you are working independently.

4). You must tell your case officer, within seven days of your becoming aware of:

• Any clinical incident you are involved in.

• Any investigation started against you.

• Any disciplinary proceedings taken against you.

5). You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

• Any agency you apply to or are registered with for work.

• Any current or future employer.

• Any educational establishment.

• Any other person(s) involved in your retraining and/or supervision required by these conditions.

6). You will send the NMC a report fourteen days in advance of the next NMC hearing or meeting from your line manager, mentor or supervisor (as agreed by your employer) dealing with your general professional conduct and nursing practice.

7). You must limit your employment to one substantial employer which can include an Agency.

8). You must ensure that you are supervised by another registered nurse anytime that you are working. Your supervision must consist of working at all times on the same shift as, but not always directly observed by, another registered nurse.

9). You must not be the nurse in charge of a shift.

10). You will send your case officer evidence that you have successfully completed an assessed course in medication management which should include storage, administration and record keeping.

11.) You must work with your line manager, mentor or supervisor (as agreed by your employer) to create a personal development plan (PDP).

- Your PDP must address the concerns about medication management which should include storage, administration and record keeping.

- You must send your case officer a copy of your PDP, to include your progress against the identified objectives, fourteen days before the review hearing.

The period of this order is for 9 months. The panel considered that this length of order was sufficient time to enable you to evidence that you have continued to develop your insight and further strengthened your practice.

Before the order expires, a panel will hold a review hearing. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

1) Your continued engagement with this process which includes your attendance at the review hearing.

2) A written reflective piece addressing the charges found proven with a focus on the potential risk to patients, the impact on the reputation of the profession and how your practice has changed.

3) Any workplace references/testimonials that you wish to obtain.

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel 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 your own interest until the conditions of practice 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 Kyriacou and you.

Ms Kyriacou submitted that an interim order should be made in order to allow for the possibility of an appeal to be lodged and determined. She submitted that an interim conditions of practice order for a period of 18 months should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest. She submitted that conditions for the interim order should be the same as those detailed in the substantive order.

You did not object to this application.

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. In reaching its decision, the panel had regard to the reasons set out in its decision for the substantive order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover the period of any potential appeal.

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

That concludes this determination.