Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday 12 October 2022 – Friday 14 October 2022
Monday 17 October 2022 – Thursday 20 October 2022
Tuesday 25 October 2022 – Friday 28 October 2022
Tuesday 9 May 2023 – Friday 12 May 2023

2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	**Maria Demetriou**
NMC PIN:	87Y1667E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (December 1990) Nurse Independent/Supplementary Prescriber Nurse Prescribing – (June 2016)
Relevant Location:	Derby, Derbyshire and Nottinghamshire
Type of case:	Lack of competence and Misconduct
Panel members:	Nicholas Rosenfeld (Chair, Lay member) Florence Mitchell (Registrant member) Konrad Chrzanowski (Lay member)
Legal Assessor:	Paul Housego (12 October 2022 – 14 October 2022) Ian Ashford-Thom (17 October 2022 – 28 October 2022),
Hearings Coordinator:	Charis Benefo (12 October 2022 – 14 October 2022), (17 October 2022 – 28 October 2022) Opeyemi Lawal (9 May 2023 – 12 May 2023)
Nursing and Midwifery Council:	Represented by Anthony James, of Counsel, Case Presenter
Mrs Demetriou:	Present and represented by Thomas Buxton, Counsel instructed by the Royal College of Nursing (RCN)

Facts proved by admission:	1(a)(i)(a), 1(a)(i)(b), 1(a)(i)(c), 1(a)(i)(d), 1(a)(iii), 1(a)(iv)(a), 1(a)(iv)(b), 1(a)(vi), 1(b)(i)(a), 1(b)(i)(b), 1(b)(i)(d), 1(b)(ii)(a), 1(b)(ii)(b) – (recording only), 1(b)(ii)(c) – (recording only), 1(b)(ii)(e), 1(b)(iii)(d), 1(b)(iv)(a), 1(b)(iv)(b), 1(b)(v), 1(b)(vi), 1(b)(vii), 1(b)(viii)(b)(i), 1(b)(viii)(b)(ii), 1(b)(viii)(b)(iii), 1(b)(viii)(b)(iv), 1(b)(x)(a), 1(b)(x)(b), 1(b)(x)(c), 3(a)(i), 3(a)(ii), 3(a)(iii), 3(a)(iv)(a), 3(a)(iv)(b), 3(a)(v)(a), 3(a)(v)(b), 3(a)(v)(c), 3(a)(vi), 3(b), 6(a)
Facts proved:	1(a)(v)(a), 1(a)(v)(b), 1(b)(i)(e), 1(b)(ii)(b) – (assessing only), 1(b)(ii)(c) – (assessing only), 1(b)(ii)(d), 1(b)(iii)(a), 1(b)(iii)(b), 1(b)(iii)(c), 1(b)(iv)(c), 1(b)(iv)(d) – partially proved (recording only),1(b)(viii)(a), 1(b)(ix)(a) – did not record but did have discussion,1(b)(xi)(a), 1(b)(xi)(b), 1(b)(xi)(c), 1(c)(ii), 3(a)(vii), 4(b), 5 in relation to Charge 4b
Facts not proved:	1(a)(ii), 1(b)(xii)(a) – No evidence offered, 1(b)(xii)(b) – No evidence offered,1(c)(i),1(c)(iii), 2(b), 2(c)(i), 2(c)(ii), 3(c)(i), 3(c)(ii), 4(a), 6(b), 6(c), 7, 8
No case to answer:	1(b)(i)(c), 1(b)(ix)(b), 2(a)(i), 2(a)(ii)
Fitness to practise:	**Impaired**
Sanction:	**Conditions of Practice Order (18 months)**
Interim order:	**Conditions of Practice Order (18 months)**

Details of charge [as amended]:

That you,

1. during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows

    a. you did not make accurate records in that you:

        i. did not label smear samples correctly or at all in respect of:
            a) Patient 1 **[PROVED BY ADMISSION]**
            b) Patient 2 **[PROVED BY ADMISSION]**
            c) Patient 3 **[PROVED BY ADMISSION]**
            d) Patient 7 **[PROVED BY ADMISSION]**

        ii. On or around 26 January 2018, in relation to Patient 6 failed to review and/or record a review of their steroid dose despite a request to do so from a senior colleague **[NOT PROVED]**

        iii. On or around 30 January 2018 in respect of Patient 8 did not complete the template following a spirometry test. **[PROVED BY ADMISSION]**

        iv. On or around 7 February 2018, in relation to Patient 9, commenced nutilis powder without:
            a) Recording your rationale for doing so; **[PROVED BY ADMISSION]**
            b) Discussing and/or recording a discussion with a prescribing clinician. **[PROVED BY ADMISSION]**

        v. On or around 3 April 2018 in respect of Patient 16 did not:

a) asses and/or record your assessment of the risk of heart attack or stroke **[PROVED]**
b) discuss and/or record a discussion with the patient about statins **[PROVED]**

vi. On or around 21 April 2018 having administered a Typhoid vaccine to Patient 19, incorrectly recorded that you had administered a hepatitis A vaccine; **[PROVED BY ADMISSION]**

b. failed to follow safe prescribing practice in that you:

i. on or around 5 January 2018 in relation to Patient 4, increased metformin medication and/or added alogliptin without
a) Assessing the response to an increase in metformin from 4 December 2017 **[PROVED BY ADMISSION]**
b) recording the response to an increase in metformin from 4 December 2017 **[PROVED BY ADMISSION]**
c) recognising that diarrhoea could be a symptom of metformin **[NO CASE TO ANSWER]**
d) Ensuring a new blood test had been taken after 4 December 2017 **[PROVED BY ADMISSION]**
e) Warning Patient 4 of potential side effects of alogliptin **[PROVED]**

ii. on or around 22 December 2017, in relation to Patient 5 started a new medication without:
a) Following the plan already in place; **[PROVED BY ADMISSION]**
b) Assessing and/or recording an assessment of the patient's blood sugar diary; **[PROVED BY ADMISSION – RECORDING ONLY, PROVED ON ASSESSING]**
c) Assessing and/or recording an assessment of the patient's response to gliclazide. **[PROVED BY ADMISSION – RECORDING ONLY, PROVED**

ON ASSESSING]

d) Warning Patient 5 of potential side effects of alogliptin; **[PROVED]**

e) Discussing and/or recording a discussion with a prescribing clinician. **[PROVED BY ADMISSION]**

iii. On or around 12 January 2018 in relation to patient 5, increased the dose of alogliptin without:

a) Assessing and/or recording an assessment of whether the patient had any hypoglycaemia; **[PROVED]**

b) Assessing and/or recording an assessment of the patient's response to gliclazide **[PROVED]**

c) Warning Patient 5 of potential side effects of alogliptin; **[PROVED]**

d) Discussing and/or recording a discussion with a prescribing clinician. **[PROVED BY ADMISSION]**

iv. On or around 16 November 2017, in respect of Patient 10, added a prescription for Relvar Inhaler, without:

a) Recognising that the Revlar Inhaler was a specialist initiation drug; **[PROVED BY ADMISSION]**

b) Removing Symbicort from their prescription; **[PROVED BY ADMISSION]**

c) Providing a dosage instruction; **[PROVED]**

d) Discussing and/or recording a discussion with a prescribing clinician. **[PARTIALLY PROVED – ON RECORDING ONLY]**

v. on or around 16 March 2018 added a prescription for metformin for Patient 11 without discussing and/or recording a discussion with a prescribing clinician. **[PROVED BY ADMISSION]**

vi. on or around 22 March 2018 added a prescription for statins for Patient 13 without discussing and/or recording a discussion with a prescribing clinician. **[PROVED BY ADMISSION]**

vii. on or around 22 March 2018 increased the prescribed dose of sulphonylureas for Patient 14 without discussing and/or recording a discussion with a prescribing clinician. **[PROVED BY ADMISSION]**

viii. On or around 22 March 2018, in respect of Patient 12:

a) added a prescription for metformin for without discussing and/or recording a discussion with a prescribing clinician; **[PROVED]**

b) restarted Losartan without:

i) ensuring the patient had a kidney function test; **[PROVED BY ADMISSION]**

ii) giving advice and/or recording that advice had been given that Losartan can affect kidney function; **[PROVED BY ADMISSION]**

iii) considering, or recording consideration of the patient's liver function test; **[PROVED BY ADMISSION]**

iv) advising the patient to see his GP about the liver function test. **[PROVED BY ADMISSION]**

ix. On or around 29 March 2018 in relation to Patient 15, reauthorized warfarin:

a) without discussing and/or recording a discussion with a prescribing clinician; **[PROVED – DID NOT RECORD BUT DID HAVE DISCUSSION]**

b) outside of your area of competence **[NO CASE TO ANSWER]**

x. On or around 4 April 2018 in relation to Patient 17

a) Added an overdose of prednisolone to the patient's prescription **[PROVED BY ADMISSION]**

b) Added a duplicate prescription of doxycycline **[PROVED BY ADMISSION]**

c) Did not discuss and/or record discussion with a prescribing clinician in relation to the above **[PROVED BY ADMISSION]**

xi. On or around 19 April 2018 recorded a consultation with Patient 18 regarding a depo provera injection and did not discuss and/or record a discussion with the patient about:
   a) The importance of the timing of the injection **[PROVED]**
   b) Risk of pregnancy **[PROVED]**
   c) current contraception **[PROVED]**

xii. On or around 27 January 2018 in respect of Patient 20 demonstrated poor infection control in that:
   a) Your uniform was not clean **[NO EVIDENCE OFFERED]**
   b) You did not change your gloves between attempts to take a smear test **[NO EVIDENCE OFFERED]**

c. Failed to complete an asthma review appropriately for Patient 3 in that you:
   i. Did not conduct a medication review; **[NOT PROVED]**
   ii. Did not give an asthma plan to Patient **[PROVED]**
   iii. Demonstrated poor infection control in that your uniform was not clean **[NOT PROVED]**

2. during your employment with Oakhill Medical Practice between 15 August 2018 – July 2019 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows:

a. Acted outside the scope of your training and competence when you, on or around 3 May 2019:
   i. Interpreted an ECG **[NO CASE TO ANSWER]**
   ii. gave feedback to the patient on the ECG **[NO CASE TO ANSWER]**

b. Did not demonstrate safe infection prevention and control in that you disposed of bloodied cotton wool and/or used syringes in the general waste bin on or

around 9 May 2019 **[NOT PROVED]**

c. Did not keep accurate records in that you:

i. On 22 May 2019 carried out a consultation with Patient 24 and did not make a record of the consultation in the patient notes **[NOT PROVED]**

ii. On 24 June 2019 following a consultation with Patient 23 recorded an incorrect INR result and recorded the colour of the tablet instead of the dosage **[NOT PROVED]**

3. during your employment with Ashfield House Surgery 1 October 2018-27 January 2020 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows

a. did not keep accurate records when you:

i. Mixed up two patients when sending a cervical smear sample on or around 9 May 2019; **[PROVED BY ADMISSION]**

ii. Did not include a valid sample taker code on a cervical smear sample for Patient 27 on or around 18 April 2019 **[PROVED BY ADMISSION]**

iii. Did not include the patient DOB and/or NHS number on a cervical smear sample for Patient 28 on or around 16 May 2019 **[PROVED BY ADMISSION]**

iv. On or around 4 June 2019 having taken a sample from Patient 25
   a. incorrectly labelled the vial to say the sample was taken on 3 June 2019; **[PROVED BY ADMISSION]**
   b. incorrectly labelled the sample from Patient 26, as being from Patient 25.

[PROVED BY ADMISSION]

v. In respect of cervical samples you took on 15 August 2019:
   a. did not include a valid sample taker code for Patient 32; **[PROVED BY ADMISSION]**
   b. entered an incorrect post code for Patient 31; **[PROVED BY ADMISSION]**
   c. entered an incorrect address for Patient 32; **[PROVED BY ADMISSION]**

vi. In respect of cervical samples you took on or around 15, 19 August and 22 August 2019 used the incorrect request form for Patients 30, 31, 32, 33, 34, 35, 36, 37 and 38. **[PROVED BY ADMISSION]**

vii. Recorded the incorrect manufacturer on influenza vaccination records for Patients 39, 40 and 41. **[PROVED]**

b. Did not follow safe medicines administration protocol in that, on 10 June 2019, you administered an out of date Hepatitis B vaccine to Patient 29. **[PROVED BY ADMISSION]**

c. Did not follow safe infection prevention control in that, on 9 September 2019, you:

   i. Did not wash your hands before starting, or in between patient consultations **[NOT PROVED]**
   ii. Placed used syringes on a desk rather than dispose of them in the sharps bin **[NOT PROVED]**

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

That you, a registered nurse:

4. Failed to complete an asthma review appropriately for Patient 3 in that you:

    a. Documented that you had completed a medication check when you had not; **[NOT PROVED]**
    b. Documented that you had given the patient an asthma action plan when you had not; **[PROVED]**

5. Your actions as set out in charges 4a and/or 4b above were dishonest in that you sought to conceal the fact that you had not carried out those actions **[PROVED IN RELATION TO 4B]**

6. Breached patient confidentiality in that:

    a. On 5 October 2018, you disclosed Patient 21's appointment to their mother without Patient 21's consent **[PROVED BY ADMISSION]**

    b. On or around 9 May and 20 June 2019, you disposed of items containing patient identifiable information ('PII') in the general waste bin **[NOT PROVED]**

    c. On or around 20 June 2019, you disposed of prescriptions containing patient identifiable information ('PII') in the general waste bin **[NOT PROVED]**

7. On or around 7 October 2019 retrospectively amended the records for Patient 26's appointment on 4 June 2019 to indicate that you had checked the demographics on the specimen bottle and form with the receptionist when you had not. **[NOT PROVED]**

8. Your actions in charge 7 were dishonest in that you sought to hide the fact that you had not checked the details **[NOT PROVED]**

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

Background

You first entered onto the Nursing and Midwifery Council's (NMC) register in December 1990. You qualified as a Nurse Prescriber in June 2016.

The eight charges in this case provide a detailed narrative of the concerns raised about your practice.

The NMC first received a referral in respect of you on 5 June 2018 from Witness 4, Practice Nurse Manager, at the Chapel Street Medical Centre (Chapel Street Centre). Charges 1, 4 and 5 arise from this referral.

You initially commenced employment at the Chapel Street Centre in the summer of 2017 as a Practice Nurse in a locum capacity, after which you commenced a 12-month maternity leave cover contract on 1 August 2017. You were employed to complete general treatment room duties such as administering immunisations, cervical smears and wound dressings. You also saw patients with long-term conditions.

Your employment at the Chapel Street Centre ended in June 2018.

On 15 August 2018, you commenced employment at Oakhill Medical Practice (Oakhill Practice) as a Practice Nurse. Your responsibilities included cytology, travel vaccinations, venepuncture, long-term condition management, ear care, immunisations and maintaining clinical records.

You resigned from Oakhill Practice on 28 June 2019 and left the practice on the same day.

On 11 July 2019, the NMC received a second referral about your practice from Witness 5, the Practice Manager at the Oakhill Practice. The concerns included alleged poor record keeping, breaching patient confidentiality and acting outside the scope of training and competence. Charges 2 and 6 arise from this referral.

On 1 October 2018, you commenced employment at Ashfield House Surgery as an Agency Practice Nurse, and were subsequently offered a substantive position, which you accepted.

The NMC received a third referral about you on 11 September 2019 from Witness 3, the Advanced Nurse Practitioner and Partner from Ashfield House Surgery. Charges 3, 7 and 8 arise from this referral.

On 27 January 2020, you resigned from your position at Ashfield House Surgery with immediate effect.

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

Mr James, on behalf of the NMC, made a request that parts of this case be held in private on the basis that proper exploration of your case involves reference to the health of Witness 3 and to the personal circumstances [PRIVATE] of Witness 5. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Buxton, on your behalf, did not oppose the application and indicated that he had no submissions or observations on it.

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 in the public interest.

The panel determined to hold in private the parts of this hearing that involve reference to the health of Witness 3 and Witness 5's family as and when such issues are raised, in order to protect their privacy.

Decision and reasons on application to admit video link evidence

The panel heard an application made by Mr James under Rule 31 to allow Witness 2, Witness 3, Witness 4 and Witness 5 to give their evidence over video link.

Mr James indicated that following a preliminary discussion with Mr Buxton on your behalf, it was his understanding that the application in respect of Witness 2 was unlikely to be opposed but, there would be objection in relation to Witness 3, Witness 4 and Witness 5. He informed the panel that the RCN was put on notice by the NMC in an email dated 3 October 2022 that it would be making an application to admit video link evidence for four witnesses.

Mr James invited the panel to admit Witness 5's evidence via video link. He informed the panel that Witness 5 was due to give evidence after Patient 3 on day two of the proceedings, or on the morning of day three. Mr James told the panel that Witness 5 would not be present at this hearing in person and explained that she was unable to attend due to [PRIVATE].

Mr James stated that Witness 5 is not a registered nurse, and [PRIVATE].

Mr James invited the panel to admit Witness 2's evidence via video link. He informed the panel that Witness 2 would not be present at this hearing in person and that he was unable to attend the hearing due to his work commitments. Mr James told the panel that

Witness 2 had not been able to secure locum cover for his GP surgery due to recent staff turnover and had asked the NMC whether he could take time out of his working schedule to join the hearing via video link and then return to his patients.

Mr James then invited the panel to admit Witness 3's evidence via video link. He informed the panel that Witness 3 would not be present at this hearing in person and that she was unable to attend the hearing due to a combination of factors. Mr James told the panel that Witness 3 is [PRIVATE] and would be working from 08:00 to 20:00 on day one and day two of the proceedings, returning home at around 20:45. He said Witness 3 therefore felt that she would not be able to travel to Stratford after work on day two of the proceedings to arrive for the following day. Mr James stated that Witness 3 was also [PRIVATE].
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In relation to Witness 4, Mr James also invited the panel to admit her evidence via video link. He informed the panel that the initial plan had been for Witness 4 to give evidence on day one of the proceedings. However, she had not been given notice of the hearing date until the day before she travelled to Mexico, and she had indicated that she would be in Mexico until 16 October 2022, travelling home the day before she was due to give evidence. Mr James told the panel that Witness 4 could not give evidence from Mexico for a number of reasons, including connectivity, privacy and time zone issues. He stated that due to the short notice, Witness 4 had not been able to make arrangements to travel to London from Derby following her arrival from Mexico, but that she had booked off work for day four of the proceedings, and so could give evidence that day from her home via a video link.

Mr James submitted that all the witnesses were willing and able to give evidence if the panel facilitated it through video link.

Mr James referred the panel to the NMC guidance on supporting people to give evidence in hearings which outlined key principles for panels to consider. The guidance provided:

‘We know that giving evidence at a hearing can be a daunting experience for some people.
We don’t want the nature of the experience to interfere with a person’s ability to give their evidence effectively.

When preparing cases for hearings, we’ll follow these principles as part of best practice:

1. *We’ll find out what support people feel they need to give evidence in a hearing and engage effectively.*
2. *We’ll always try to provide people with the support they tell us they need as long as it is fair and practical to do so. One way we’ll do this is to work collaboratively with the parties in the case to get support measures agreed before the hearing...*’

Mr James submitted that the panel had heard what was required for each of the witnesses to engage effectively.

Mr James submitted that the Case Management Form (CMF) had been provided to the RCN in advance of the hearing to complete and return to the NMC. He stated that an option had been given in the form for the RCN to specify if a virtual or in-person hearing was preferred, or if there was no preference at all. Mr James told the panel that the RCN completed and returned the form to the NMC on 22 February 2022 but did not make an indication on the preferred type of hearing. He stated that the form also provided the names of the NMC witnesses, how the NMC thought that their evidence should be given in the hearing and boxes for the RCN to indicate whether they agreed with the NMC’s position. The NMC had indicated ‘*In-person or remote if it’s a virtual hearing*’ for each witness and the RCN responded with an indication that they agreed to this.

Mr James accepted that the CMF did not specifically address remote evidence in the event of a physical hearing. He submitted, however, that if this hearing were being held virtually, then this argument would not be taking place.

Mr James asked the panel to consider why the RCN did not initially request a physical hearing if it were so important for the witnesses to give evidence in person. He asked the panel to apply the principles of fairness and practicality. He referred the panel to the guidance on supporting people to give evidence in hearings which provided:

'…

3. *Where we consider the support requested is not practical or a reasonable use of resources, we'll work with the person giving evidence to give them as much support as we can.*
4. *We make the initial decision about support measures, but the panel hearing the case has the final say over whether support can be provided. We'll be clear about this in our communications to people giving evidence. We'll also be clear that we may have to share information about why they need support measures with other people involved in the case…'*

Mr James submitted that you and the RCN had been notified of the support the NMC was proposing to give to the witnesses 10 days prior to the hearing.

Mr James then referred the panel to the NMC guidance on the credibility of evidence. He submitted that the guidance made reference to relevant case law which he invited the panel to consider in its decision making. Mr James submitted that if Mr Buxton were to make reference to the demeanour of witnesses to properly assess their credibility, he would be asking the panel to consider the following:

‘Panels should not attempt to assess whether someone’s evidence is truthful from the manner in which it is given, such as from their appearance, tone or other aspects of their behaviour in answering questions.’

Mr James submitted that the burden was on you to show that it would not be fair to you to have the witnesses give evidence remotely. He submitted that there was no such unfairness.

Mr James therefore invited the panel to allow Witness 2, Witness 3, Witness 4 and Witness 5 to give their evidence over video link, and Witness 3 to have someone in the room at home with her during her evidence. He asked the panel to consider the impracticality of conducting the hearing if the panel were to require these witnesses to attend in person and their attendance then needed to be organised. It might not be possible to do so.

Mr James said that Witness 5 [PRIVATE].

Mr James said that Witness 3 had [PRIVATE].

In relation to Witness 4, Mr James said that she was in Mexico, travelling back the day before she was due to give evidence. It would not be realistic to expect her to travel to London the next day.

Mr Buxton informed the panel that the RCN had been put on notice of the NMC’s position on 3 October 2022. He submitted that in the NMC’s email, the reasons for the request to give evidence over video link had been foreshadowed, but that the greater detail had only been provided by the NMC on day one of the proceedings. He submitted that the RCN had indicated to the NMC that the application would be opposed, and it was unfortunate that the NMC had provided no evidence in support of its application.

Mr Buxton submitted that there appeared to be a trend in NMC proceedings where the attendance of witnesses seemed to be determined at the whim or wish of the witnesses. He submitted that where physical hearings are scheduled, it was the norm that witnesses would give evidence in person unless there was good reason for them to give evidence otherwise.

Mr Buxton asked the panel to note the declarations contained at the conclusion of the witnesses' statements. They stated that they would be willing to attend the hearing to give evidence. He submitted that whilst this did not specify physical attendance at the hearing, witnesses were informed that they may be required to give evidence in person. That was the point when the NMC should have addressed any issues that might arise.

Mr Buxton accepted that the completed CMF did not specify your position in relation to the type of hearing, but submitted this was not a virtual hearing. It was an in-person hearing. It was expected that witnesses would attend in-person hearings in person, not remotely.

Mr Buxton took a pragmatic view about Witness 2, and did not oppose that request.

Mr Buxton submitted that registered nurses, by their NMC Code, are required to co-operate and attend when they are required to give evidence by the NMC. He highlighted that this information is available on the NMC website for all to see. Mr Buxton submitted that while it was quite right for the NMC to make attending the hearing as easy as possible for witnesses, good reason had to be given for the panel to allow remote evidence in a hearing that was in person.

Mr Buxton invited the panel to examine the reasons given by the NMC and to conclude that it was not reasonable to allow remote evidence from the three other witnesses. He asked the panel to consider the matter of fairness, that you had travelled to London to stay at your own expense in order to attend the hearing and engage.

In relation to Witness 5, Mr Buxton stated that he understood that she was not an NMC registrant. He submitted, however, that the panel would need to ask itself whether the reason given by the NMC for her remote attendance was sufficient. Mr Buxton accepted that Witness 5 had to travel from Sheffield and that this might be a little inconvenient but submitted that people are capable of making such journeys and that it was known when she provided a willingness to attend that it would be expected for her to attend in person.

Mr Buxton submitted that the NMC had not provided any evidence or detail other than a report of an email exchange regarding Witness 5 about her circumstances and unwillingness to attend in person. He submitted that arrangements could be made to facilitate Witness 5's in-person evidence during the day without an overnight stay. There was no supporting documentation.

In relation to Witness 3, Mr Buxton submitted that the panel had been told without any evidence that she was suffering from [PRIVATE]. If she could not come the day after her two shifts she could give evidence on another day. Mr Buxton asked the panel to enquire who would be supporting Witness 3 during her evidence as the NMC had provided no information as to who that would be. He submitted that the NMC had not provided a valid reason for Witness 3's non-attendance at the hearing in person. There was no evidence of [PRIVATE] or why that was an impediment to travelling to give evidence when she was able to work consecutive 12-hour shifts.

Mr Buxton highlighted that on current scheduling of the hearing, Witness 4 would have returned from Mexico by the time of her oral evidence. He submitted that if she was concerned about "*jet lag*" as a reason for not attending the NMC hearing centre on day four, then the panel could address that by timetabling changes. It was not good reason for not attending on another day.

Mr Buxton submitted that it was an inescapable fact, notwithstanding the guidance relating to the credibility of witnesses, that panels find it helpful and are assisted by seeing and hearing from witnesses in person.

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 legal assessor advised the panel that the onus was on the NMC to make application for a witness to give evidence remotely. It was expected that for an application to succeed good reason should be shown why the witness ought to be permitted to give evidence remotely. The panel should obtain the best evidence available. That was evidence in person. He advised the panel that there was no right for either party to decline to bring witnesses to the hearing and to give evidence only by video link. It was usual for such applications to be supported by evidence in some form. It was for the NMC to show good reason, and not for you to show that there was unfairness in video evidence from the witness. An in person hearing self-evidently had as its starting point witnesses attending in person, and good reason had to be shown why this was not possible.

The panel gave the application in regard to Witness 2, Witness 3, Witness 4 and Witness 5 careful consideration. The panel noted that these witnesses' statements 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 each of them. Witness 3, Witness 4 and Witness 5's statements concluded '*I confirm I am willing to attend a hearing and give evidence before a Committee of the NMC if required to do so.*' Witness 2 clearly stated at the conclusion of his witness statement that he was unable to attend in person. The panel considered that the NMC had clearly given consideration to whether witnesses could attend or not and no objection was raised by the other witnesses when they made their witness statements.

The panel had regard to the NMC guidance on supporting people to give evidence in hearings and the guidance on evidence.

The panel considered that as a starting point, in physical hearings, witnesses are expected to attend and give oral evidence in person. If they sought to give evidence remotely good reason needed to be shown, preferably with some evidential basis.

In relation to Witness 5, the panel noted that arrangements could be made so that she would not need to stay in London overnight. It was of the view that Witness 5's journey time which had been suggested by the NMC had not been shown to be as long as was claimed. The panel considered that Witness 5's oral evidence was likely to be completed within a time estimate of two hours and 45 minutes, which would allow her to travel back home within a reasonable time.

The panel took into account Mr James' submissions regarding Witness 5's [PRIVATE]. The panel determined that a simple statement that she could not come was not sufficient reason to agree to Witness 5's evidence via video link.

In these circumstances, the panel refused the application in respect of Witness 5. However it was still some time until she was due to give evidence, and the NMC was at liberty to renew the application if it was able to obtain some evidence to support it.

The panel took into account that Witness 2 is not a registrant and could not be compelled to attend the hearing in person. He had always made clear that he could not attend and the RCN had not objected to this. The panel noted that Witness 2 had made efforts to cover his work with a locum, but to no avail. The panel was of the view that good evidence had been provided in advance of the hearing for Witness 2's non-attendance in person.

The panel also noted that Witness 2's evidence addressed the policies and processes at Oakhill Practice, rather than his observations of you or any specific matters he observed about your practice. The panel was satisfied that Witness 2's evidence was inherently more suitable to be given over video link.

In these circumstances, the panel came to the view that it would be fair and relevant to allow Witness 2 to give evidence via video link.

The panel noted from Mr James' submissions that Witness 3 had mentioned anxiety about recalling old events, rather than a mental health issue with anxiety. The panel appreciated that anyone would be anxious in the circumstances. The panel was aware that the NMC has a witness support officer to support Witness 3 when she attended to give oral evidence. It was not entirely satisfactory to have a supporter in the room with someone giving oral evidence without detail of who that person was, or what support was intended to be given.

The panel noted that Witness 3's [PRIVATE] did not prevent her from working 12-hour shifts on consecutive days. Nor was there any medical evidence of either condition. The panel did not feel that these were sufficient reasons for Witness 3 not to attend and give evidence in person. The panel was of the view that Witness 3's reasons amounted to no more than an expression of preference, or a reluctance to attend.

In these circumstances, the panel refused the application in respect of Witness 3.

The panel noted that Witness 4 was due to return to England the day before she had been warned to give evidence at the hearing (day four of the proceedings), and that she had booked day four off work. The panel considered that the NMC's only reason for Witness 4's proposed non-physical attendance was that arrangements could not be made in time. The panel was of the view that arrangements could be made for Witness 4 to travel to the NMC hearing centre on day four, or for her evidence to be rescheduled for another day with no detriment to her.

In these circumstances, the panel refused the application in respect of Witness 4.

The panel considered that the parties were expected to accommodate these witnesses within the timetable and make all necessary reasonable adjustments that meet their needs, to ensure that the panel is given the best evidence.

The panel invited the NMC to make a further application if supporting evidence were provided to support the NMC's submissions, particularly in relation to Witness 5. It would be helpful if the witnesses (other than Witness 4) could make statements clearly detailing the reasons they sought to give evidence remotely.

Decision and reasons on the request to reconsider the panel's decision to refuse the request to admit video link evidence

On day two of the proceedings, Mr James submitted that all parties including the NMC had approached the application on the wrong basis. He submitted that insufficient attention had been paid to the NMC's guidance. It was for you to show that it was unfair to you for evidence to be given remotely, not for the NMC to show good reason. He submitted that the panel's decision not to allow Witness 3, Witness 4 and Witness 5 to give their evidence over video link was at odds with the NMC guidance. He invited the panel to refer to the guidance on evidence and supporting people to give evidence in hearings again and in particular, to only take into account the principles of fairness and practicality.

Mr James stated that the NMC had no additional evidence to provide to the panel at that stage, but that it was the NMC's position to make further application to admit the video link evidence of Witness 3, Witness 4 and Witness 5. Mr James submitted that the panel had approached the matter in the wrong way. The NMC's guidance was that evidence could be given in a number or ways, in person or by video link. There was no unfairness in evidence being given in this way.

Mr Buxton reminded the panel that it had made a final decision and had determined that the application could be made again only if further evidence was provided in relation to the witnesses.

The panel heard and accepted the advice of the legal assessor. He referred the panel to CPR 32(2) of the Civil Procedure Rules 1998, which sets out that the starting point was that in a hearing evidence is given in person. The panel may allow video evidence. That did not mean it had to do so. It was for the NMC to show good reason why evidence should be given by video link and the panel had decided that this had not been done. He advised that the LexisNexis guidance note titled '*Witness Evidence – giving evidence remotely in civil proceedings*' referred to Article 6 of the European Convention on Human Rights (which he said applied to this hearing) and which stated '*Although a direction for evidence by video link is not necessarily contrary to the Convention or the overriding objective, the court must ensure that such a direction is 'made for a good reason and serves a legitimate aim''* (*The Three Mile Inn Ltd & Ors v Dale* [2012] EWCA Civ 970).

That note also stated that '*it should not be assumed that a court will be ready to accept a request for evidence to be given remotely just on grounds of costs savings and proportionality. Similarly, requests based on generalised notions of convenience lack persuasiveness.*' The examples given of when remote evidence was likely to be accepted were of health, or personal or financial jeopardy to the witness.

The legal assessor also referred the panel to the Law Society note on '*Remote evidence*'. This was that remote hearings seem to be working well in simple procedural hearings involving only judges and advocates, such as directions hearings or case management hearings, cases involving more sophisticated parties and/or legal entities, such as in the English and Welsh commercial courts and more technical or administrative proceedings. However, the Law Society indicated that remote hearings worked less well in cases which involved live evidence or significant controversy, such as tribunals, criminal, county and family courts and complex cases, such as contested family hearings.

The legal assessor referred to the NMC guidance on evidence, which stated:

'*Our rules don't dictate how evidence should be given and people can give evidence to a panel in a number of ways. This includes attending a hearing centre, over video-link or by telephone.*

In most circumstances, there is no disadvantage in someone giving evidence by video-link compared to appearing in the same room as the panel. In some cases it may be better to give evidence by video-link rather than over the telephone, although telephone evidence may still be considered a fair way for the witness to give their evidence.'

The legal assessor advised that it was entirely correct, as evidence can be given remotely. That guidance did not give the right to the NMC (or to a registrant) to call evidence remotely. The legal assessor did not consider Mr James' submission that it was for you to show that it was unfair to you for evidence to be given remotely was correct. It was for the NMC to show good reason. The panel had decided that it had not done so for three witnesses. The application was not based on any new information and so it was difficult to see a basis for revisiting those decisions.

The panel accepted the advice of the legal assessor. It took into account its decision not to admit the video link evidence of Witness 3, Witness 4 and Witness 5. It also noted its invitation for the NMC to make a further application only if it could provide evidence to support the submissions. The panel determined that it would not entertain a further application on admitting video link evidence unless evidence was provided by the NMC in respect of Witness 3, Witness 4 and Witness 5.

NMC offering no evidence

Mr James informed the panel that the NMC would be offering no evidence on charge 1b)xii in its entirety. He submitted that this did not undermine the overall seriousness of the case and that on review, there was no realistic prospect of charge 1b)xii being found proved.

Mr Buxton did not object.

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

The panel accepted that the NMC had good reason to offer no evidence on charge 1b)xii in its entirety and accordingly dismissed the charge.

Decision and reasons on the request to make a further application to admit video link evidence

On day four of the proceedings, Mr James informed the panel that the NMC had received further information, comprising telephone call logs and photographs, to renew its application to admit Witness 3 and Witness 5's video link evidence.

Mr James stated that the NMC had provided the panel with the summary of two telephone calls between Witness 5 and the NMC Case Coordinator on 13 October 2022 at 09:30 and 13:31, which explained her personal circumstances. [PRIVATE]. He submitted that the NMC felt it was not appropriate to "*dig deeper*" and ask Witness 5 for further evidence relating to her son's health as it was concerned that it could lose Witness 5 as an NMC witness, given her distress.

Mr James submitted that the NMC had provided two photographs [PRIVATE] and the summary of two telephone calls between Witness 3 and the NMC on 13 October 2022 at 09:34 and 14 October 2022 at 16:00. He submitted that Witness 3 had provided a clear account of her difficulties, with evidence in the form of photographs.

Mr James told the panel that Witness 3 was the "*Flu Lead*" at work and that she would be required to be on the premises all week. He stated that she had cleared her scheduled to give evidence from work via video link if the panel were content for her to do so. Mr James informed the panel that Witness 3 was willing to attend the hearing in person, but that she would require five to seven days to make alternative arrangements. He submitted that if the application in respect of Witness 3 were accepted by the panel, she would be able to give evidence between 12:00 and 15:00 on day four of the proceedings.

Mr James submitted that the panel had been provided with sufficient information to enable the NMC to renew its application to admit Witness 3 and Witness 5's video link evidence.

Mr Buxton submitted that very little had changed in light of the panel's earlier decision that it would invite the NMC to first obtain evidence to support its arguments before making a further application to admit video link evidence. He submitted that the documents provided to the panel did not amount to evidence in the sense that the panel had intended.

Mr Buxton submitted that the NMC had provided undated photographs in relation to Witness 3's medical condition, but had not provided medical evidence.

Mr Buxton submitted that the call logs in relation to the witnesses simply indicated that they were getting angry or upset that they were not getting their own way. He submitted that the information provided was nothing more than evidence of witnesses pushing back and saying that they would only attend the hearing to give evidence if it were via video link.

Mr Buxton submitted that if the application were to be pursued, then he would invite the panel to consider when Witness 3 and Witness 5 had first indicated difficulties and why, having been given more time to provide cogent evidence, the NMC had provided the information that was before the panel today.

The panel informed the NMC via Mr James that in line with the NMC's guidance on evidence, these matters should have been attended to at a pre-meeting between the parties before the hearing.

The panel was satisfied that the information provided by the NMC amounted to sufficient information in relation to Witness 3 and Witness 5. It considered that the NMC had met the threshold of the panel's earlier decision that it would only allow a further application from the NMC if it could provide evidence to support its submissions. The panel therefore determined that it would allow the NMC to make a substantive application to admit Witness 3 and Witness 5's video link evidence and for the panel to reconsider its decision.

Decision and reasons on application to admit Witness 3 and Witness 5's video link evidence

Mr James then made an application under Rule 31 to allow Witness 3 and Witness 5 to give their evidence over video link.

Mr James reminded the panel of Witness 5's inability to attend the hearing in London because of [PRIVATE].

Mr James asked the panel to consider the information in the telephone call log at 09:30 [PRIVATE] she was willing to appear as a witness and tell the panel about the events that made up the allegations.

Mr James submitted that Witness 3 would not be able to attend the hearing in London on the basis of her health and work commitments. He referred the panel to the summary of two telephone calls between Witness 3 and the NMC on 13 October 2022 at 09:34 and on 14 October 2022 at 16:00. Mr James also referred the panel to the two photographs.

Mr James reminded the panel that Witness 3 was [PRIVATE]. Mr James told the panel that Witness 3 had also been working reduced hours at her place of work.

Mr James submitted that whilst Witness 3 was not able to travel to London from [PRIVATE], she was willing to appear as a witness and tell the panel about the events that made up the allegations. He submitted that Witness 3's evidence pointed to charges 3, 7 and 8 and that she would be available to give evidence before the panel from 12:00 on day four of the proceedings.

Mr James submitted that there was good and sufficient reason for Witness 3 and Witness 5 to give evidence via video link. He submitted that the panel had seen how the process had worked with Witness 2 and there were no issues. He submitted that it would also be fair for the panel to allow their video link evidence, and that it was incumbent on Mr Buxton

to show any unfairness in Witness 3 and Witness 5 providing video link evidence. Mr James also asked the panel to consider the guidance he had previously highlighted.

Mr Buxton referred the panel to its earlier decision not to allow Witness 3 to give evidence via video link. He highlighted the panel's view that Witness 3's reasons amounted to no more than an expression of preference or a reluctance to attend. Mr Buxton submitted that nothing substantive had been placed before the panel to change the position, and so Witness 3 should be asked to attend the hearing in person to give her evidence.

Mr Buxton then referred to the panel's earlier decision in relation to Witness 3's ability to work 12-hour shifts on consecutive days despite [PRIVATE]. He submitted that the position seemed to have shifted to the extent that Witness 3 had reduced her shifts to accommodate [PRIVATE]. He submitted that the panel had no cogent medical evidence to indicate a diagnosis [PRIVATE]. He questioned whether a photograph [PRIVATE] and the photograph was not dated. Mr Buxton submitted that Witness 3's [PRIVATE] had not been made out at all.

Mr Buxton submitted that in view of the panel's earlier decision, it could not properly decide to allow Witness 3's video link evidence on the basis that the journey might be uncomfortable for her. He submitted that the panel should refuse the application, and suggested that [PRIVATE] could be made available to Witness 3 in any event.

Mr Buxton referred the panel to the summary of the telephone call between Witness 3 and the NMC on 14 October 2022 at 16:00 and highlighted the information from Witness 3 that she could not run the GP surgery safely without notice. He asked why the NMC did not take account of this in September 2022 and ask Witness 3 to obtain cover in advance. The NMC Case Coordinator had asked Witness 3 if there was a possibility that she could attend the hearing on day four of the proceedings, and her response was that she had taken time out to give evidence on day three of the proceedings and that:

'…*It is ridiculous*

The GMC doesn't operate this way

…

I'm a witness I've not gone [sic] anything wrong

This would put anybody off making a referral, it certainly would me

I understand [Witness 2] is not going in to London…'

Mr Buxton reminded the panel that it had noted that the witnesses, with the exception of Witness 2, had made a declaration at the conclusion of their witness statements that they would be able to attend the hearing to give evidence. He highlighted that Witness 3 appeared to have mentioned Witness 2, but that Witness 2 was not a member of Ashfield House Surgery. He asked the panel to consider that Witness 3 had been made aware that Witness 2 was attending the hearing to give evidence via video link. He submitted that her stance was likely to have been that if Witness 2 could give evidence via video link, then she should be able to do the same and that following this, she provided information to the NMC that her availability was limited.

Mr Buxton submitted that it was ultimately a matter for the panel, but the panel would have to remind itself that Witness 3 is a registered nurse. Mr Buxton submitted that it was not a question satisfying the panel that it would be unfair for Witness 3 to give evidence, but that the panel had made an earlier decision that she must attend unless there was good reason why she could not.

In relation to Witness 5, Mr Buxton referred the panel to its earlier decision not to allow her to give evidence via video link and in particular, its invitation to the NMC to renew its application if it could obtain some evidence to support it. He stated that the information before the panel confirmed that [PRIVATE].

Mr Buxton referred to the panel to the summary of two telephone calls between Witness 5 and the NMC on 13 October 2022 at 09:30 and 13:31 which supported Mr James' submission that the NMC could lose Witness 5 as a witness entirely. [PRIVATE].

Mr Buxton submitted that arrangements could be made to ensure that Witness 5 would not have to stay in London overnight to complete her evidence. [PRIVATE]. He invited the panel to refuse the application in respect of Witness 5.

Mr Buxton submitted that this case was dependent on documentary evidence and included patient records which had been reproduced in small and illegible copies. He submitted that there could be confusion by different members of the hearing as to what these records indicate. Mr Buxton submitted that it would be preferable for all members of the hearing to look at the same documents in the same medium to avoid issues of this nature.

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 gave the application in regard to Witness 3 and Witness 5 serious consideration.

The panel noted that it was not in issue that the evidence of Witness 3 and Witness 5 was relevant. The issue was one of fairness.

In relation to Witness 3, the panel had regard to the two photographs she had provided, and the summary of two telephone calls between Witness 3 and the NMC on 13 October 2022 at 09:34 and on 14 October 2022 at 16:00. The panel noted Witness 3's indication that she [PRIVATE]. It also took into account the information that Witness 3 was [PRIVATE].

The panel considered that it had not been provided with medical evidence to [PRIVATE].

However, since its earlier decision, it had been provided with additional information about [PRIVATE]. The panel determined that it was more willing to accept the application in respect of Witness 3 as it had been provided with a better explanation for her non-attendance in person.

The panel took into account that Witness 3's [PRIVATE]. The panel determined that [PRIVATE] outweighed the need for her to attend the hearing in person.

The panel considered that you would not be significantly disadvantaged by the NMC's reliance upon the live testimony of Witness 3 via video link evidence.

In the circumstances the panel decided that it would be fair for the panel to receive Witness 3's evidence via video link.

In respect of Witness 5, the panel had regard to the summary of two telephone calls between Witness 5 and the NMC Case Coordinator on 13 October 2022 at 09:30 and 13:31. [PRIVATE].

The panel took into account that whilst Witness 5 was still able to work, she was only 10 minutes away from home [PRIVATE].

The panel also took into account [PRIVATE].

The panel considered that it had not been provided with [PRIVATE]. However, since its earlier decision, it had been provided with additional information which had placed the application in a different context. The panel determined that it was more willing to accept the application in respect of Witness 5 as it had been provided with a better explanation for her non-attendance in person.

The panel considered that you would not be significantly disadvantaged by the NMC's reliance upon the live testimony of Witness 5 via video link evidence.

In the circumstances the panel decided that it would be fair for the panel to receive Witness 5's evidence via video link.

The panel considered that it was always the preference that witnesses give evidence in person for in-person hearings, and that remote evidence via video link was the next best option.

Decision and reasons on application to admit Witness 4's video link evidence

The panel heard an application made by Mr James under Rule 31 to allow Witness 4 to give her evidence over video link. He referred the panel to the summary of a telephone call between Witness 4 and the NMC Case Coordinator on 17 October 2022 at 09:30. The NMC Case Coordinator had advised Witness 4 that the panel had objected to her video link evidence and required her attendance in person. The call log stated:

> '*[Witness 4] stated that it is not impossible to come to London to give evidence but that would cause a lot of problems. She added that she is the Flu Lead for the surgery as such she has to be on site to ensure that the flu vaccine is administered to their patients in line with their processes.*
> *She also stated that she has cleared her schedule for today and tomorrow (17th and 18th October) so she can give evidence virtually however if the panel insists that she has to come to come to London, she would need 5-7 days to make alternative arrangements at the surgery.*'

Mr James told the panel that whilst Witness 4 had cleared her schedule to give evidence on day four and day five of the proceedings, she was required to remain on site at work until the end of the month. He submitted that this additional information provided an explanation on the question of whether Witness 4 would be able to attend the hearing in person after her arrival from Mexico.

Mr Buxton submitted that you were anxious to have the case move ahead and avoid the risk of the case not completing on time. He reminded the panel of its earlier considerations and decision in respect of Witness 4. Mr Buxton submitted that the panel had not been told that Witness 4 was the Flu Lead at work prior to this stage. He submitted that he could not understand how a Flu Lead would need to remain on site, but highlighted from the note that whilst it was '*not impossible*' for Witness 4 to come to London, this would cause problems. Mr Buxton submitted that it would not be desirable for Witness 4 to be given a week to rearrange her diary.

Mr Buxton conceded to the NMC's application to admit Witness 4's video link evidence.

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 gave the application in regard to Witness 4 serious consideration.

The panel noted the information that Witness 4 was the Flu Lead at work and therefore required to remain on site until the end of the month. The panel appreciated the importance of a Flu Lead and the potential impact on patients at a medical centre if a Flu Lead were not on the premises. The panel took into account that Witness 4 had cleared her schedule for day four and day five of the proceedings to give evidence from work via video link. It also took into account that it would take Witness 4 five to seven days to make alternative arrangements if the panel were to require her in-person attendance. The panel was also mindful of Mr Buxton's submission that you were eager for the case to progress.

The panel considered that you would not be significantly disadvantaged by the NMC's reliance upon the live testimony of Witness 4 via video link evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to allow Witness 4 to give evidence remotely via video link.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Buxton that there is no case to answer in respect of charges 1b)i)c, 1b)i)e, 1b)ii)c, 1b)ii)d, 1b)iii)c, 1b)ix)b, 2a)i and 2a)ii and 2c)i and 2c)ii. This application was made under Rule 24(7). This rule states:

> *'24 (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –*
>
> *(i) either upon the application of the registrant, or*
> *(ii) of its own volition,*
>
> *the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.'*

In relation to this application, Mr Buxton referred the panel to the case of *R v Galbraith* [1981] 1 WLR 1039, which laid down that there would be no case to answer where there was either no evidence to support the allegation (limb one) or where the evidence was so tenuous (because of inherent vagueness, weakness or inconsistency with other evidence) that no properly directed panel could find the matter proved (limb two). Mr Buxton also referred to the case of *R v Shippey* [1988] Crim LR 767 and submitted that if the evidence, taken at its highest is so poor that a panel cannot find the charge proved, then the charge must be withdrawn.

Mr Buxton submitted that there was insufficient evidence to find charges 1b)i)c and 1b)i)e proved. He stated that the panel had received Patient 4's patient notes which included

consultation entries made by Ms 6, you and Witness 4, as well as Witness 4's handwritten notes when reviewing the records. Mr Buxton said that the panel also had regard to Witness 4's witness statement. He submitted that Patient 4's statements to Witness 4 during a conversation about the consultation with you amounted to hearsay and was inadmissible evidence which could not form part of the panel's consideration of the charges. Mr Buxton submitted that in accordance with the first limb of *Galbraith*, there was no evidence to substantiate the allegations in charges 1b)i)c and 1b)i)e.

In relation to charges 1b)ii)c and 1b)ii)d, Mr Buxton referred the panel to the relevant patient records in respect of Patient 5, as well as the oral evidence and witness statement of Witness 4. Mr Buxton submitted that the allegation at charge 1b)ii)c (that you did not assess Patient 5's response to gliclazide) was an assertion that was based on nothing more than Patient 5's patient record on 22 December 2022. Further, on charge 1b)ii)d, Mr Buxton submitted that there was no evidence that you failed to warn Patient 5 of the potential side effects of alogliptin.

On charge 1b)iii)c, Mr Buxton submitted that this related to Patient 5's consultation with you on 12 January 2018. He asked the panel to consider the relevant patient records in respect of Patient 5 and submitted that there was no evidence that you failed to warn Patient 5 of the potential side effects of alogliptin. He submitted that it was a feature of this case that the patient records on SystmOne had been "*gone through with a fine tooth comb*". Mr Buxton submitted that where it had been suggested that a complete narrative of the content of conversations had not been recorded, it had been wrongly suggested that that would form the basis of an allegation that you failed to warn the patient of possible side effects as alleged at the charge.

Mr Buxton submitted that in relation to charge 1b)ix)b, he would be making submissions on the first limb of *Galbraith*. He reminded the panel that the NMC's witnesses were asked in their oral evidence whether they were aware of your prescribing qualification, and that there was no definitive account or assertion from any of the witnesses that they were aware of the nature of your qualifications or whether reauthorising warfarin was outside

your area of competence. Mr Buxton submitted that this was a different matter from the Chapel Street Centre's '*Repeat Prescribing Protocol*' and whether or not reauthorising warfarin fell within this this policy.

In relation to charges 2a)i and 2)a)ii, Mr Buxton submitted that the relevant evidence was set out in the witness statements of Witness 5 and Witness 2. Witness 5's statement stated that:

> *'I do not know what feedback the registrant gave to [the patient concerned] or how it was established that she had given this feedback. We do not have a policy setting out this process but it is a practice role to complete tasks requested by the GP.'*

Mr Buxton also referred to Witness 2's witness statement which stated that:

> *'Even if she believes she was able to do so, this was outwith [sic] the role in which she was employed and her actions were not sanctioned or supported by the partners.'*

Mr Buxton submitted that both of these witnesses were directly asked about what they could tell the panel about the events contained at charges 2a)i and 2a)ii, and they were not able to provide any evidence on this. He submitted that neither of these witnesses came up to proof in respect of these allegations. Mr Buxton submitted that the evidence on these charges was wholly lacking under limb one of *Galbraith*. However, if the panel were to find that these witness statements amounted to evidence on the charges, then it was inherently vague and tenuous under limb two of *Galbraith*.

Mr Buxton submitted that at its highest, the evidence on charge 2c)i amounted to your appointment diary from Oakhill Practice dated 22 May 2019. He submitted that the issue in respect of this charge was whether or not a consultation with Patient 24 took place at all, notwithstanding the appointment diary dated 22 May 2019. Mr Buxton submitted that there was no evidence that you had a consultation with Patient 24 and that accordingly, the

charge must fail. He referred the panel to the SystmOne notes of Patient 24 showing entries for the period between 26 April 2019 to 21 August 2019, and indicated that there was no entry for a consultation on 22 May 2019 by you. Mr Buxton submitted that there was no evidence to prove whether or not a consultation took place. He invited the panel to find no case to answer on this charge under the first limb of *Galbraith*, and if not, it was his suggestion that the evidence was weak, inconsistent and vague.

In relation to charge 2c)ii, Mr Buxton invited the panel to consider Witness 2's witness statement. He stated that Witness 2's oral evidence was that he was ambivalent and didn't seem concerned with the question about the colour and dosage of the tablet. Mr Buxton referred the panel to Patient 23's SystmOne notes for 14 June 2019 as well as their '*Anticoagulant Treatment Record*'. He submitted that an important point to note about Patient 23's SystmOne entry was that they were a 78 year old female patient. He also highlighted that Patient 23's consultation note on 14 June 2019 indicated that an appointment had been made for 24 June 2019. Mr Buxton submitted that Patient 23's '*Anticoagulant Treatment Record*' was an unedifying document and that the evidence in relation to its purpose, where it came from and how it came to be in the possession of Witness 5 was unsatisfactory. He referred the panel to Witness 5's handwritten note on the bottom of the '*Anticoagulant Treatment Record*' document which stated:

> *'9.40 is the appointment time <u>not</u> INR*
> *We use tablet grams not colour'*

Mr Buxton submitted that the entry on this record could not be safely ascribed to you. Mr Buxton submitted that the evidence on this charge was so poor and unsatisfactory that the panel could not properly find this allegation proved.

In these circumstances, it was submitted by Mr Buxton that these charge should not be allowed to remain before the panel.

Mr James referred the panel to the NMC guidance on no case to answer and emphasised the guidance that:

> *'Where the strength or weakness of our evidence depends on the weight it should be given, a submission that there is no case to answer is likely to fail. That issue is best considered after all the evidence has been heard.'*

Mr James submitted that he had no observations on Mr Buxton's submissions in respect of charge 1b)i)c.

Mr James stated that he would make identical submissions on charges 1b)i)e, 1b)ii)d and 1b)iii)c as these charges related to the side effects of alogliptin. He asked the panel to consider the mantra "*if it is not recorded, it did not happen*" and referred the panel to the notes of the meeting between you, Witness 4 and a doctor at Chapel Street Centre on 26 January 2018. He submitted that several issues were raised in this meeting but in particular, the notes stated that:

> *'Maria was asked what specific advice she may give to a person when initiating alogliptin and she was unable to answer other than 'general GI effects' suggesting a lack of knowledge regarding the potentially dangerous side effects of Alogliptin.'*

Mr James asked the panel to consider how you could warn patients of the side effects during a consultation if you were unable to answer that question in the meeting. He submitted that on the NMC's evidence, there was a case to answer in respect of these charges.

In relation to charge 1b)ii)c, Mr James reminded the panel of your admission at the outset of this hearing that on or around 22 December 2017, in relation to Patient 5, you started a new medication without recording an assessment of the patient's response to gliclazide. He submitted that the matter in question was whether you assessed the patient's

response to gliclazide. Mr James referred the panel to Patient 5's blood test results dated 10 November 2017 and their SystmOne notes for the period between 28 November 2017 and 12 January 2018. He submitted that you appeared to have mistakenly referred to previous blood test results at your consultation with Patient 5 on 22 December 2017 and that there was no evidence that you carried out an assessment into Patient 5's response to gliclazide. Mr James accepted Mr Buxton's submission that there was no evidence from Patient 5 however, he submitted that it was clear from the documentary evidence that you could not have assessed Patient 5's response.

Mr James stated that on charge 1b)ix)b, Witness 4 had given evidence before the panel that you were not employed at Chapel Street Centre as a prescriber and that you were specifically asked not to prescribe. He referred the panel to Witness 4's witness statement which indicated that warfarin is a powerful drug and that there was a reason why it could only be issued once. Mr James submitted that the panel had received evidence from Witness 4 that you should have referred the matter to a GP. He asked the panel to consider the question that if reauthorising was in your area of competence, then why would you have to refer it to a GP. Mr James referred the panel to the Chapel Street Centre's '*Repeat Prescribing Protocol*' which provided that warfarin on repeat prescription would only be reauthorised one time and that patients would need an up to date INR check. He submitted that this was supported by the notes of your formal disciplinary meeting dated 17 May 2018.

Mr James highlighted Witness 4's oral evidence that nurses generally within Chapel Street Centre would not reauthorise warfarin. He submitted that Witness 4 had provided clear evidence about this issue to show that you acted outside your competence. Mr James submitted that there was no evidence that this was in your competence, but that if it was, then Witness 4 and Chapel Street Centre would have known about it. He submitted that there was ample evidence that you reauthorised warfarin outside the area of your competence.

Mr James submitted that he had no observations on Mr Buxton's submissions in respect of charges 2a)i and 2a)ii, save that the panel had sight of Witness 5's witness statement and could make of it what it will.

In relation to charge 2c)i, Mr James submitted that your appointment diary from Oakhill Practice dated 22 May 2019 confirmed that your consultation with Patient 24 was an INR appointment. He highlighted that the appointment entry above Patient 24's entry was in a different colour (green as opposed to purple), which according to Witness 5 indicated that the patient had not attended the appointment. Mr James submitted that on the NMC's evidence so far, if the consultation with Patient 24 did not take place, then it would appear in green on the diary. However Patient 24's entry was in purple and included a door and green arrow icon which meant that they did attend Oakhill Medical Practice and did enter the consultation room with you. Mr James submitted that there was tangible evidence that Patient 24 was seen by you on 22 May 2019.

Mr James submitted that despite the entry on the appointment diary, there were no entries on Patient 24's SystmOne notes about this appointment. He submitted that on the evidence, you did the consultation with Patient 24 but did not record it on SystmOne. Mr James accepted that there was no evidence from Patient 24, but submitted that there was compelling circumstantial evidence which did not meet the two limbs of *Galbraith*.

On charge 2c)ii, Mr James submitted that Mr Buxton's submissions lost sight of the present stage of the hearing. He submitted that this stage was not a matter of whether your fitness to practise was impaired, but a question of whether the facts could be found proved. Mr James stated that Patient 23's SystmOne notes for 14 June 2019 included an automatic '*INRstar*' input and that the entry recorded by you only made reference to the colours of the tablets, but there was no reference at all to the milligrams of the tablets. He submitted that there was also no mention of the milligrams of the tablets on Patient 23's '*Anticoagulant Treatment Record*'. Mr James submitted that in relation to the incorrect INR result, the charge was definitely supported by the evidence on a factual basis.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has 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 you had a case to answer.

In relation to charge 1b)i)c, the panel noted the stem of the charge, namely that on or around 5 January 2018 in relation to Patient 4, you increased metformin and/or added alogliptin without recognising that diarrhoea could be a symptom of metformin. The panel took into account Patient 4's SystmOne notes, particularly the entries from Ms 6's appointment with Patient 4 on 4 December 2017. The panel noted that Ms 6 had prescribed two tablets in the morning and two tablets in the evening for Patient 4 which equated to two grams of metformin. The entry from the appointment with you on 5 January 2018 indicated '*good compliancy with Metformin at 2 tablets am and 1 tablet pm with food, all options discussed, Metformin increased to 2 tablets BD with food*'. The panel considered that Patient 4 should not have been taking only one pm tablet at that time. It was therefore satisfied that you did not actually increase the dosage, but reinstated the original dose of two grams per day as prescribed by Ms 6 on 4 December 2017. The panel determined that as there was no evidence that you increased Patient 4's metformin dose, the charge at 1b)i)c fell away.

The panel was therefore satisfied that, taking account of all the evidence before it, there was no realistic prospect that it could find the facts of charge 1b)i)c proved.

On charge 1b)i)e, the panel noted the stem of the charge, namely that on or around 5 January 2018, you increased metformin and/or added alogliptin without warning Patient 4 of the potential side effects of alogliptin. The panel took into account your admission at the outset of the hearing that you added alogliptin on 5 January 2018, as well as your entry

from the appointment which stated '*Alogliptin 25mg also commenced, adv given re-possible side effects…'*.

The panel had regard to the notes of the meeting between you, Witness 4 and a doctor at Chapel Street Centre on 26 January 2018. The panel noted that this meeting took place three weeks after the appointment with Patient 4 and that one of the matters discussed was the issue around alogliptin. The panel considered that on this evidence, you were unable to answer the question about the specific advice you may give to a person when initiating alogliptin.

The panel was therefore satisfied that there had been sufficient evidence to support charge 1b)i)e at this stage and, as such, it was not prepared to accede to an application of no case to answer.

Regarding charge 1b)ii)c, the panel noted Patient 5's SystmOne notes and the entry from the appointment with you on 22 December 2017 which indicated '*states good compliancy with Metformin/Gliclazide'.* The panel also took into account your admission at the outset of the hearing that you had not recorded an assessment of Patient 5's response to gliclazide on 22 December 2017. The panel considered that if you had not recorded an assessment of Patient 5's response, then it had no evidence before it to rebut the possible inference that you had not carried out the assessment.

The panel was therefore satisfied that there had been sufficient evidence to support charge 1b)ii)c at this stage and, as such, it was not prepared to accede to an application of no case to answer.

In its consideration of charge 1b)ii)d, the panel noted the stem of the charge, namely that on or around 22 December 2017, you started a new medication without warning Patient 5 of the potential side effects of alogliptin. It also took into account your admission at the outset of the hearing that on or around 22 December 2017, in relation to Patient 5, you

started a new medication. The panel considered that there was no record on Patient 5's SystmOne notes that you provided advice to them of the potential side effects of alogliptin.

The panel had regard to the notes of the meeting between you, Witness 4 and a doctor at Chapel Street Centre on 26 January 2018. It considered that this meeting took place three weeks after the appointment with Patient 4 and that one of the matters discussed was the issue around alogliptin. The panel considered that on this evidence, you were unable to answer the question about the specific advice you may give to a person when initiating alogliptin.

The panel was therefore satisfied that there had been sufficient evidence to support charge 1b)ii)d at this stage and, as such, it was not prepared to accede to an application of no case to answer.

In relation to charge 1b)iii)c, the panel noted the stem of the charge, namely that on or around 12 January 2018, in relation to Patient 5, you increased the dose of alogliptin without warning Patient 5 of the potential side effects of alogliptin. It also took into account your admission in respect of this charge that you increased the dose of alogliptin.

The panel noted Patient 5's SystmOne notes and the entry from the appointment with you on 12 January 2018 which indicated '*Alogliptin is increased to 25mg with adv*'. However, there was nothing in the record to indicate what advice, if any, had been given or whether it related to side effects.

The panel had regard to the notes of the meeting between you, Witness 4 and a doctor at Chapel Street Centre on 26 January 2018. It considered that this meeting took place three weeks after the appointment with Patient 4 and that one of the matters discussed was the issue around alogliptin. The panel considered that on this evidence, you were unable to answer the question about the specific advice you may give to a person when initiating alogliptin.

The panel was therefore satisfied that there had been sufficient evidence to support charge 1b)iii)c at this stage and, as such, it was not prepared to accede to an application of no case to answer.

On charge 1b)ix)b, the panel noted the wording of the charge, namely that on or around 29 March 2018, in relation to Patient 15, you reauthorised warfarin outside of your area of competence.

The panel had regard to Patient 5's SystmOne notes and the entry from the appointment with you on 29 March 2018 which indicated that you reauthorised warfarin. It took into account Chapel Street Centre's '*Repeat Prescribing Protocol*' which indicated that warfarin could not be reauthorised more than once and would need to be completed by a GP. The panel had also heard evidence from Witness 4 that you were told not to reauthorise warfarin and that this was not within your scope of employment. Witness 4 indicated words to the effect that: generally nurses do not reauthorise warfarin, none of the practice nurses can do this. [The registrant] was not employed as a prescribing nurse. We asked [the registrant] not to prescribe, it could be within her competency, I don't know.

The panel had not heard evidence at this stage as to your level of competency to reauthorise warfarin. It noted that Witness 4 could not give a definitive answer as to whether this act was outside of your level of competency. It also considered that the NMC had not provided evidence from which it could legitimately infer that you did not have the necessary competence.

The panel was therefore of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 1b)ix)b proved.

Regarding charge 2a)i and 2a)ii, the panel noted that it had heard clear evidence from Witness 2 and Witness 5 that it was not appropriate for you to interpret an ECG and give feedback to a patient. However the panel took into account that it had not been provided

with any evidence that you did in fact interpret an ECG and give feedback to the patient concerned. The panel noted Witness 5's witness statement which stated that:

> *'I do not know what feedback the registrant gave to [the patient concerned] or how it was established that she had given this feedback.'*

The panel noted that Witness 5 did not give oral evidence on this charge, that Witness 2 could not provide any oral evidence regarding this patient, and that it had also not heard any evidence from the patient concerned.

The panel was therefore satisfied that, taking account of all the evidence before it, there was no realistic prospect that it could find the facts of charges 2a)i and 2a)ii proved.

In its consideration of charge 2c)i, the panel noted your appointment diary from Oakhill Practice dated 22 May 2019 which indicated that Patient 24 attended the practice for an INR appointment to be seen by you. The panel had regard to the evidence that this consultation took place as Patient 24's entry on this diary was coloured purple and included a door and green arrow icon. The panel also considered Patient 24's SystmOne notes and noted that there was no entry or record on 22 May 2019 detailing the consultation.

The panel was therefore satisfied that there was some evidence, which taken at its highest, could support charge 2c)i at this stage and, as such, it was not prepared to accede to an application of no case to answer.

The panel then considered charge 2c)ii and noted the wording of the charge, namely that on 24 June 2019, following a consultation with Patient 24, you recorded an incorrect INR result and recorded the colour of the tablet instead of the dosage. The panel considered that this charge related to two allegations. The panel had regard to Patient 23's SystmOne notes dated 14 June 2019 which detailed an appointment with you. The panel had not been provided with any notes for an appointment on 24 June 2019 in respect of Patient

23. It noted that your entry on 14 June 2019 that an appointment had been made for 24 June 2019 was the only reference to the date provided in the charge.

In relation to the allegation that you recorded the incorrect INR result, the panel noted Patient 23's '*Anticoagulant Treatment Record*' where an entry of '*9.40*' had been made in the '*INR*' column and dated '*24/6/19*'. It also took account of Witness 5's witness statement and oral evidence.

In relation to the allegation that you recorded the colour of the tablet instead of the dosage, the panel noted Patient 23's '*Anticoagulant Treatment Record*' where an entry of '*4X BROWN'* had been made in the '*comments*' column and dated '*24/6/19*'. The panel was satisfied that the colour of the tablet had been recorded but that there was no reference to the dosage on Patient 23's record.

The panel was therefore satisfied that there was some evidence, which taken at its highest, could support the two allegations at charge 2c)ii at this stage and, as such, it was not prepared to accede to an application of no case to answer.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr James to amend the wording of charges 3a)ii, 3a)iii, 3a)v)a, 3a)v)b, 3a)v)c, 3a)vi and 3a)vii.

The proposed amendment was to identify which patients were involved in each alleged incident. It was submitted by Mr James that the proposed amendments did not change the substance of the allegations, but would provide clarity and more accurately reflect the evidence.

"That you,

3. during your employment with Ashfield House Surgery 1 October 2018-27 January 2020 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows

    a. did not keep accurate records when you:

        …

        ii. Did not include a valid sample taker code on a cervical smear sample **for Patient 27** on or around 18 April 2019

        iii. Did not include the patient DOB and/or NHS number on a cervical smear sample **for Patient 28** on or around 16 May 2019

            …

        v. In respect of cervical samples you took on 15 August 2019:
            a) did not include a valid sample taker code for ~~one patient~~ **Patient 32**;
            b) entered an incorrect post code for ~~one patient~~ **Patient 31**;
            c) entered an incorrect address for ~~one patient~~ **Patient 32**;

        vi. In respect of cervical samples you took on or around 15, 19 August and 22 August 2019 used the incorrect request form for ~~a number of patients~~ **Patients 30, 31, 32, 33, 34, 35, 36, 37 and 38**.

        vii. Recorded the incorrect manufacturer on influenza vaccination records for ~~three patients~~ **Patients 39, 40 and 41**."

Mr Buxton submitted that he had no issue with the proposed amendments to charges 3a)ii, 3a)iii, 3a)v)a, 3a)v)b, 3a)v)c, 3a)vi and 3a)vii.

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

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 you 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

At the outset of the hearing, the panel heard from Mr Buxton, who informed the panel that you made admissions through your representative or during your evidence to the following charges 1(a)(i)(a), 1(a)(i)(b), 1(a)(i)(c), 1(a)(i)(d), 1(a)(iii), 1(a)(iv)(a), 1(a)(iv)(b), 1(a)(vi), 1(b)(i)(a), 1(b)(i)(b), 1(b)(i)(d), 1(b)(ii)(a), 1(b)(ii)(b) – (recording only), 1(b)(ii)(c) – (recording only), 1(b)(ii)(e), 1(b)(iii)(d), 1(b)(iv)(a), 1(b)(iv)(b), 1(b)(v), 1(b)(vi), 1(b)(vii), 1(b)(viii)(b)(i), 1(b)(viii)(b)(ii), 1(b)(viii)(b)(iii), 1(b)(viii)(b)(iv), 1(b)(x)(a), 1(b)(x)(b), 1(b)(x)(c), 3(a)(i), 3(a)(ii), 3(a)(iii), 3(a)(iv)(a), 3(a)(iv)(b), 3(a)(v)(a), 3(a)(v)(b), 3(a)(v)(c), 3(a)(vi), 3(a)(vii), 3(b), 6(a).

The panel therefore finds charges 1(a)(i)(a), 1(a)(i)(b), 1(a)(i)(c), 1(a)(i)(d), 1(a)(iii), 1(a)(iv)(a), 1(a)(iv)(b), 1(a)(vi), 1(b)(i)(a), 1(b)(i)(b), 1(b)(i)(d), 1(b)(ii)(a), 1(b)(ii)(b) – (in respect of recording only), 1(b)(ii)(c) – (in respect of recording only), 1(b)(ii)(e), 1(b)(iii)(d), 1(b)(iv)(a), 1(b)(iv)(b), 1(b)(v), 1(b)(vi), 1(b)(vii), 1(b)(viii)(b)(i), 1(b)(viii)(b)(ii), 1(b)(viii)(b)(iii), 1(b)(viii)(b)(iv), 1(b)(x)(a), 1(b)(x)(b), 1(b)(x)(c), 3(a)(i), 3(a)(ii), 3(a)(iii), 3(a)(iv)(a), 3(a)(iv)(b), 3(a)(v)(a), 3(a)(v)(b), 3(a)(v)(c), 3(a)(vi), 3(a)(vii), 3(b), and 6(a) 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 Mr James on behalf of the NMC and by Mr Buxton on your behalf.

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:

- Patient 3: Patient of Chapel Street Medical Centre;
- Witness 2: GP Partner at Oakhill Medical Practice;
- Witness 3: Advanced Nurse Practitioner and Partner at Ashfield House Surgery;
- Witness 4: Practice Nurse Manager at Chapel Street Medical Centre;
- Witness 5: Practice Manager at Oakhill Medical Practice at the time.

The panel also heard evidence from you under oath.

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 both the NMC and Mr Buxton on your behalf.

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

Charge 1(a)(ii)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    a. *you did not make accurate records in that you:*

        ii. *On or around 26 January 2018, in relation to Patient 6 failed to review and/or record a review of their steroid dose despite a request to do so from a senior colleague*

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary, supplementary and oral evidence of Witness 4, which included the document created by Witness 4 on the records relating to Patient 6, and the documentary records relating to Patient 6. The panel also took into account the evidence provided by you.

The panel noted from your oral evidence:

> *'I would disagree with that by saying that on reflection historically my review statements or sentences were too broad. However, I know now that I have been a lot more specific. So, by saying that "feels well, no new problems, states no asthma triggers currently evident", it says "advice given on healthy lifestyle, medication review done, possible side-effects discussed". Part of that was the steroid dosage and usage. Obviously, he said that he did not have any problems. He never mentioned any problems and one of the side-effects of repeated high doses of steroid can lead to pneumonia. When I was questioning him, he did not say anything about his concern with steroid use; that is why I sent a task to Witness 4, asking for clarification because I did a medication review, I reviewed his steroid*

inhaler as well. If he was not happy or if he did actually want his steroid inhaler because of his concerns (unclear) Witness 4 then he would have told me.'

The panel noted from the documentary records relating to Patient 6, under *'Fri 26/Jan/2018 … MD',* you wrote:

'Attended for asthma rev,
states feels well,
no new problems,
states no asthma triggers currently evident,
adv given re-healthy lifestyle choices/modifications,
medication rev done,
possible side effects discussed,
all options/possible red flags discussed,
safety netting adv givne,
to re vprn,
adv givne,
TRIN/111 service.'

From this, the panel was satisfied that a review had taken place for Patient 6. It was of the view that the meeting with Witness 4 involved you asking what was required and seeking clarification. The panel was of the view that, although your record keeping was not good, there is evidence of you inputting a record. It noted that you accept your record keeping skills are not of a high standard, but there is evidence of the review taking place, particularly as you had inputted *'medication rev done'.*

In light of the above, the panel determined that on the balance of probabilities, it is more likely than not that, a review had taken place for Patient 6 and you had recorded that review, albeit not comprehensively. The panel, therefore, did not find this charge proved.

Charge 1(a)(v)(a)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    a. *you did not make accurate records in that you:*

        v. *On or around 3 April 2018 in respect of Patient 16 did not*

            a) *asses and/or record your assessment of the risk of heart attack or stroke*

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and oral evidence of Witness 4, which included the consultation sheet in relation to Patient 16 which was completed by you. The panel also took into account the evidence provided by you.

The panel noted that there was no specific information about a heart attack or a stroke in the consultation sheet in relation to Patient 16 which was completed by you.

You told the panel during your oral evidence:

> *'[…] it would be under the umbrella of possible risks that recorded "all options discussed". It would be … I am holding my hand up high that my documentation was too broad. On reflection and hindsight I needed to add not just for this patient but for a lot of the other patients I needed to ask more specifics and document more specifics, but things were discussed. It is under the "all options discussed". With anything that they are taking or want to take, all possible side effects*

discussed. I gave them safety netting so they would not leave my office without knowing exactly what went on, what was going on and what would be going on in the future.'

[…]

In my documentation at the time I definitely discussed the statins. As far as a read code or as far as specificity, no, but that was discussed at the point of the appointment.'

The panel noted that *'all options discussed'* does not give much information about what was discussed. The panel was of the view that you may have assessed the risk, but that there was no information or evidence before it to show that you had recorded your assessment of the risk of heart attack or stroke.

In light of the above, the panel determined that on the balance of probabilities, it is more likely than not that, you did not record your assessment of the risk of heart attack or stroke. The panel, therefore, finds this charge proved.

Charge 1(a)(v)(b)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    a. *you did not make accurate records in that you:*

        v. *On or around 3 April 2018 in respect of Patient 16 did not*

b) discuss and/or record a discussion with the patient about statins

This charge is found proved.

In reaching this decision, the panel took into account the supplementary evidence of Witness 4, which included the consultation sheet in relation to Patient 16 which was completed by you, Witness 4's meeting notes with you on 26 January 2018 and the evidence provided by you.

The panel noted from the consultation sheet in relation to Patient 16 which was completed by you:

'QRisk checked or done. Statins – on or excepted: Yes'

You told the panel, in response to Mr James:

'Yes. This is not clear because on my copy it says "estimated QRISK", then it is a full stop and then "51%".

[…]

It means that the QRISK takes into account the patient's age, gender, their BMI, whether they smoke, whether they drink alcohol. It is basically their lifestyle choices. Then you put these recordings into the template and it finally gives you the QRISK of possibly having a heart attack. In that (unclear) is whether you have had a relative under the age of 50, whether under 60 or 65; that goes into the QRISK calculation. So the percentage that is given after the equals sign gives the probability of having a heart attack.

[…]

You will see, across my documentation, what is evidently lacking, which is my fault, are specifics that I did not write enough specifics. I would make blanket points or sentences that did not give enough information for the follow-on clinician, be it a doctor or a nurse. Again, after a lot of reflection -- a lot -- I sat a record-keeping course, a time management course and an assertiveness course.

[…]

That was referring to Anne's 51% for this patient. "Statins on or excepted", it was to assess whether they would accept going on to statins. So I signposted them to the Live Well website; that will give suggestions and guide a patient perhaps to make healthier lifestyle choices and modifications.'

You also told the panel that you did discuss and/or record a discussion about statins with Patient 16. You also said that:

'From my documentation, no, although I was referring to the risk assessment that Anne had made, but I signposted the patient to the various departments that would help him make healthy modifications. So by my saying "QRISK checked or done, yes", I should have put more specific information in there but my thought process was that the QRISK had already been done, the assessment had already been done.

[…]

Again, it would be under the umbrella of possible risks that recorded "all options discussed" ... I am holding my hand up high that my documentation was too broad. On reflection and hindsight I needed to add not just for this patient but for a lot of the other patients I needed to ask more specifics and document more specifics, but things were discussed. It is under the "all options discussed". With anything that they are taking or want to take, all possible side effects discussed. I gave them

safety netting so they would not leave my office without knowing exactly what went on, what was going on and what would be going on in the future.

[…]

In my documentation at the time I definitely discussed the statins. As far as a read code or as far as specificity, no, but that was discussed at the point of the appointment.

[…]

You will see, across my documentation, what is evidently lacking, which is my fault, are specifics that I did not write enough specifics. I would make blanket points or sentences that did not give enough information for the follow on clinician, be it a doctor or a nurse […]'

In light of the above, the panel was satisfied that you may have discussed with Patient 16 about statins. However, it determined that on the balance of probabilities, it is more likely than not that, you did not record a discussion with specific reference to statins. The panel, therefore, finds this charge proved.

Charge 1(b)(i)(e)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

   b. failed to follow safe prescribing practice in that you:

i. on or around 5 January 2018 in relation to Patient 4, increased metformin medication and/or added alogliptin without

e) Warning Patient 4 of potential side effects of alogliptin

This charge is found proved.

In reaching this decision, the panel took into account the documentary and supplementary evidence of Witness 4, which included the consultation sheet in relation to Patient 4 which was completed by you, Witness 4's meeting notes with you on 26 January 2018 and notes of the disciplinary meeting dated 17 May 2018. The panel also took into account the evidence provided by you.

You told the panel that you had put *'alogliptin 25mg also commenced'* following a discussion with a clinician. You said that:

> *'All possible red flags discussed, what could be the implications. Safety netting advice given, what to do and where to come to if he needed advice. I always say to review PRN being as and when […]'*

You told the panel that the side effect of alogliptin potentially is the patient can get pancreatitis. You said that you went through the symptoms of pancreatitis so the patient was in no doubt how to identify the symptoms. You said that alogliptin would cause or could cause GI issues such as diarrhoea and vomiting. It can also cause inflammation of certain organs like the pancreas and that could lower their blood sugar significantly, in which case the patient could suffer from a hypoglycaemic episode.
You told the panel that you advised Patient 4 that the side effects include diarrhoea, vomiting, the pancreas inflaming, abdominal pain, and could cause a drop in the patient's blood sugar.

However, the panel took into account the notes of the disciplinary meeting dated 17 May 2018. It noted from the meeting notes:

> *'Maria was asked what specific advice she may give to a person when initiating alogliptin and she was unable to answer other than 'general GI effects'… suggesting a lack of knowledge regarding the potentially serious side effects of Alogliptin.'*

The panel noted that you stated that you did not see the meeting notes and so you do not agree with them. You told the panel:

> *'These notes were written after the meeting by Witness 4. I was never given a copy, I never signed to say I received a copy and therefore I cannot give total validation to these notes because I was not aware of them. The fact that she said what I said, how am I supposed to give evidence on something that I have never seen but that I am supposed to have said?'*

You also told the panel that Witness 4:

> '[…] *has severely bent the truth, severely bent and changed the truth.'*

The panel preferred the evidence of Witness 4 as it determined that she was a credible and reliable witness on this issue, and it accepted the record of the meeting dated 17 May 2018 and further accepted the meeting notes with you on 26 January 2018 as accurate.

The panel was of the view that, taking into account your responses in the disciplinary meeting dated 26 January 2018, the panel was satisfied that you did not know the side effects of alogliptin. Consequently, you did not warn Patient 4 of the potential side effects.

In light of the above, the panel determined that on the balance of probabilities, it is more likely than not that, you added alogliptin without warning Patient 4 of its potential side effects. The panel, therefore, finds this charge proved.

Charge 1(b)(ii)(b)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    b. *failed to follow safe prescribing practice in that you:*

        ii. *on or around 22 December 2017, in relation to Patient 5 started a new medication without:*

            b) *Assessing and/or recording an assessment of the patient's blood sugar diary;*

This charge is found proved.

The panel took into account the admission you had made at the outset of this hearing in respect of '*recording*' for charge 1(b)(ii)(b). It considered that the dispute on this charge related to '*assessing*'.

In reaching this decision, the panel took into account the documentary and supplementary evidence of Witness 4, which included the documentary records relating to Patient 5. The panel also took into account the evidence provided by you.

The panel noted from Witness 4's witness statement:

‘17. I produce a document I created relating to Patient 5 which includes her blood test results; journal entries made by me and the registrant; and my handwritten notes when reviewing the records […] Patient 5 was a 40 year old lady who came to see me in November 2017 following blood tests she had had on 10 November 2017. I increased her gliclazide medication which is a drug used to treat type 2 diabetes. I asked her to carry out blood testing at home as I was concerned about her having low blood sugars. I asked her to come back in two weeks to review her blood sugar diary in response to gliclazide induction.

[…]

Hypoglycaemia is when blood sugar levels are low. The registrant reviewed Patient 5 a few weeks later and doubled the alogliptin.

18. The registrant should have followed the plan set out in Patient 5 records following my previous review with her. She should have assessed what Patent 5 response was to the gliclazide and for safety to see if she had had any hypoglycaemia. If the registrant had assessed this and decided that the gliclazide change I had made was not working, she should have reduced it back down or stopped it and then made reference to this in the notes.

19. Patient 5 had a number of investigations following the discovery of the error but all were within acceptable parameters and we did not find any evidence of harm. However, there was a risk that Patient 5 could have been having hypoglycaemic Attacks.

20. When we spoke to the registrant I asked her what advice she would give a patient regarding alogliptin and she was unable to answer other than to say "general GI effects" (gastrointestinal) which suggested a lack of knowledge of the potentially serious side effects of the drug. Alogliptin can lead to pancreatitis which

is an inflammation of the pancreas. Left untreated it can be fatal. I advised the registrant of this side effect and told her that she would need to advise patients of this.

21. Dr Matthews and I acknowledged that the actions taken by the registrant may in time be appropriate but advised that steps had been missed out and there was a lack of documentation regarding her decision making process. Nurses may well have a better idea than GPs of what patients should be taking as they deal with them regularly. A nurse can make a suggestion, put the medication on a prescription and then discuss it with the relevant person, a doctor or prescriber, who then signs the prescription…

22. We agreed at the time that the registrant must read back through the recent notes for each patient and document her decision making process. We said that she would need to document which prescribing clinician she has discussed prescribing suggestions with and not to simply ask a GP to sign the prescription or ideally to ask the GP to initiate the prescription.'

The panel had sight of the documentary records relating to Patient 5 produced by Witness 4. There was no evidence that you had assessed the patients' blood sugar diary within the patient's records.

The panel took into account your oral evidence. You said:

'Despite the fact that Anne highlighted this patient to me, this is how I remember it. As far as not being up to scratch, I admit that my documentation lacked specifics. It was too much of a blanket statement, although everything was discussed because I also cover "all options discussed, safety netting advice given". Again, if for whatever reason, not due to alogliptin but the blood sugar falls, which can happen if the patient has not eaten that day or enough that day, I cover the things that the patient must do in order to raise the blood sugar, but my documentation was too broad.'

The panel was of the view that you had taken Patient 5's HBA1C reading from 10 November 2019 and did not assess any response to the increased gliclazide which was prescribed on 28 November 2019. The panel was therefore of the view that you had not undertaken a full assessment of Patient 5, as there is no mention of this patient's blood sugar diary, in your record.

In light of the above, the panel determined that on the balance of probabilities, it is more likely than not that, in relation to Patient 5 that you started a new medication without assessing the patient's blood sugar diary. The panel, therefore, finds this charge proved.

Charge 1(b)(ii)(c)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    b. *failed to follow safe prescribing practice in that you:*

        ii. *on or around 22 December 2017, in relation to Patient 5 started a new medication without:*

            c) *Assessing and/or recording an assessment of the patient's response to gliclazide.*

This charge is found proved.

The panel took into account the admission you had made at the outset of this hearing in respect of '*recording*' for charge 1(b)(ii)(c). It considered that the dispute on this charge related to '*assessing*'.

For the same reasons as charge 1(b)(ii)(b), the panel determined that on the balance of probabilities, it is more likely than not that, in relation to Patient 5 you started a new medication without assessing the patient's response to gliclazide. The panel, therefore, finds this charge proved.

Charge 1(b)(ii)(d)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    b. *failed to follow safe prescribing practice in that you:*

        ii. *on or around 22 December 2017, in relation to Patient 5 started a new medication without:*

            d) *Warning Patient 5 of potential side effects of alogliptin;*

This charge is found proved.

For the same reasons as charge 1(b)(i)(e), the panel determined that on the balance of probabilities, it is more likely than not that, you added alogliptin without warning Patient 5 of the potential side effects of alogliptin. The panel, therefore, finds this charge proved.

Charge 1(b)(iii)(a)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    b. *failed to follow safe prescribing practice in that you:*

        iii. *On or around 12 January 2018 in relation to patient 5, increased the dose of alogliptin without:*

            a) *Assessing and/or recording an assessment of whether the patient had any hypoglycaemia;*

This charge is found proved.

In reaching this decision, the panel took into account the supplementary evidence of Witness 4 which was the documentary records relating to Patient 5. The panel also took into account the evidence provided by you.

The panel noted that you accept that you had increased the dose of alogliptin from 12.5mg to 25mg.

The panel had sight of Patient 5's documentary records which contains no mention of hypoglycaemia.

In response to Mr James, you told the panel that you entered *"no problems or side effects currently noted"* as a recording as to whether Patient 5 had any hypos. You also said to the panel that you could have been more specific by putting in the words *"no hypos detected",* but your point was *"no problems or side-effects currently noted".*

The panel was of the view that this was inadequate and does not demonstrate that you had assessed whether Patient 5 had any hypoglycaemia. In the absence of any evidence of the assessment, the panel determined that on the balance of probabilities, it is more likely than not that, you increased the dose of alogliptin without assessing and/or recording an assessment of whether Patient 5 had any hypoglycaemia. The panel, therefore, finds this charge proved.

Charge 1(b)(iii)(b)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    b. *failed to follow safe prescribing practice in that you:*

        iii. *On or around 12 January 2018 in relation to patient 5, increased the dose of alogliptin without:*

            b) *Assessing and/or recording an assessment of the patient's response to gliclazide*

This charge is found proved.

In reaching this decision, the panel took into account the supplementary evidence of Witness 4 which was the documentary records relating to Patient 5 and the evidence provided by you.

The panel had sight of Patient 5's documentary records which does make reference to 12 January 2018 but does not reference gliclazide.

The panel does not have any evidence before it of the assessment and the recording of the assessment of Patient 5's response to gliclazide following an increase by Witness 4. In the absence of this, the panel determined that on the balance of probabilities, it is more likely than not that, you increased the dose of alogliptin without assessing and/or recording an assessment of Patient 5's response to gliclazide. The panel, therefore, finds this charge proved.

Charge 1(b)(iii)(c)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    b. *failed to follow safe prescribing practice in that you:*

        iii. *On or around 12 January 2018 in relation to patient 5, increased the dose of alogliptin without:*

            c) *Warning Patient 5 of potential side effects of alogliptin;*

This charge is found proved.

For the same reasons as charges 1(b)(i)(e) and 1(b)(ii)(d), the panel determined that on the balance of probabilities, it is more likely than not that you added alogliptin without warning Patient 5 of potential side effects of alogliptin. The panel, therefore, finds this charge proved.

Charge 1(b)(iv)(c)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    b. *failed to follow safe prescribing practice in that you:*

        iv. *On or around 16 November 2017, in respect of Patient 10, added a prescription for Relvar Inhaler, without:*

            c) *Providing a dosage instruction;*

This charge is found proved.

In reaching this decision, the panel took into account the documentary and supplementary evidence of Witness 4, which included the documentary records relating to Patient 10. The panel also took into account the evidence provided by you.

The panel noted from Witness 4's witness statement:

> '35. […] *On 7 March 2018 the registrant had added to the prescription a Relvar inhaler which is used to treat asthma. This was not necessarily a problem in terms of the drug but it is a specialist initiation only drug within Derby and therefore prescribed by a specialist hospital or a specialist within the surgery. The registrant has ignored that it is a specialist initiation only drug and has gone ahead and prescribed it. Had she been employed in a prescribing capacity she could have*

prescribed the drug but would then have needed to have recorded her rationale in the patient record.

36. The registrant told me that where she usually worked Relvar was not a specialist initiation only drug, which I accept. Drugs can be specialist initiation only in one area and not in others, it is one of the difficulties of being a locum nurse. However, there is a warning system in place on SystmOne called Optimise RX which flags specialist initiation only drugs when they are selected. Locally within the formulary there is a traffic light system. Green means that the drug can be prescribed, brown indicates that it is a specialist initiation only drug and black means that the medication should not be prescribed at all. When a specialist initiation only drug is selected a big box flashes up which says the use of the product is not recommended except in exception circumstances. I would take that to mean that all other options have been tried and they have not worked, or for specific reasons the specialist initiation only drug is considered the best option or all you are left with.

37. The Relvar inhaler was a replacement for Symbicort which Patient 10 had already been prescribed. Symbicort also treats asthma and as such the registrant should have removed the Symbicort from the prescription to avoid Patient 10 having both inadvertently. The registrant did not do this. When I spoke to the senior doctor about this he said he would not have initiated the Relvar inhaler as it is a specialist initiation drug only. Additionally the registrant has not provided a dosage instruction so the patient would not have known from the pharmacy drug label how much and how often to take the medication.

38. As the registrant was not employed in a prescribing capacity she should have discussed her rationale with me or one of the doctors and a decision could have been made. Having prescribed the Relvar the registrant should have recorded a dosage instruction and her rationale for prescribing the medication. She should also have removed the Symbicort inhaler from the prescription.

39. There was no harm as a result of the error. The error in isolation was not a concern. Ultimately Relvar could well have been the right medication for Patient 10 and they may well have ended up being prescribed the medication. The issue is that she did not follow the correct process.'

The panel had sight of the update created by Witness 4 on SysmOne for Patient 10's record on 9 May 2018. It stated:

'Hi Maria,
Can you discuss with Dr […] sorting the repeat prescriptions for this lady please. She still has symbicort on repeat whilst you were trialling Relvar but it remains on there so needs updating please. Relvar dosage instructions need correcting to reflect what she's supposed to be taking please (As it's Specialist Initiation only I've never used it and don't know enough about it to be able to do it for you, sorry) and may be worth writing to her respiratory team to let them know you've started it and seems to be working for her as looks like they were considering Xolair.'

The panel also had sight of the prescription which reads as:

'07/March/2018
Revlar […]
30 dose – Following specialist recommendation
[…]'

The panel noted that no specific instructions as to how Patient 10 should take their dose of Relvar or how frequently. The panel were of the view that 'following specialist recommendation' does not constitute to a dosage instruction.

In light of the above, the panel determined that on the balance of probabilities, it is more likely than not that, you added a Relvar Inhaler to Patient 10's prescription without providing a dosage instruction. The panel, therefore, finds this charge proved.

Charge 1(b)(iv)(d)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    b. *failed to follow safe prescribing practice in that you:*

        iv. *On or around 16 November 2017, in respect of Patient 10, added a prescription for Relvar Inhaler, without:*

            d) *Discussing and/or recording a discussion with a prescribing clinician.*

This charge is found partially proved in respect of recording.

In reaching this decision, the panel took into account the documentary and supplementary evidence of Witness 4, which included the documentary records relating to Patient 10. The panel also took into account the evidence provided by you.

The panel noted that this medication is a 'specialist initiation only' and cannot be prescribed without authorisation from a doctor.

The panel noted from Witness 4's oral evidence:

'I cannot see anything to confirm that a discussion had taken place.'

The panel noted from Witness 4's witness statement:

> *'37. […] When I spoke to the senior doctor about this he said he would not have initiated the Relvar inhaler as it is a specialist initiation drug only […]'*

During your oral evidence, in response to Mr James, you told the panel that you did not record that discussion with a prescribing clinician in the journal for Patient 10.

The prescription was not signed. However, the panel noted that there was a doctor's name at the at the bottom of the prescription and it was of the view that it was more likely than not that a discussion had taken place.

Therefore, having determined that a discussion had taken place, there was however, no evidence before the panel that this discussion was documented.

In light of the above, the panel determined that on the balance of probabilities, it is more likely than not that, you did not record the discussion you had with a clinician when you added a prescription for Relvar Inhaler for Patient 10. The panel, therefore, finds this charge proved.

Charge 1(b)(viii)(a)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

   b. *failed to follow safe prescribing practice in that you:*

viii. On or around 22 March 2018, in respect of Patient 12:

a) added a prescription for metformin without discussing and/or recording a discussion with a prescribing clinician;

This charge is found proved.

In reaching this decision, the panel took into account the supplementary evidence of Witness 4 which included the consultation sheet in relation to Patient 12 dated 22 March 2018. The panel also took into account the evidence provided by you.

The panel had sight of the consultation sheet in relation to Patient 12 which was completed by you:

'Metformin 500mg - 1 tablet BD with food (titrated dosage)'

During your evidence, you accepted that you added Metformin to the prescription. You also told the panel that you went to the doctor's room with that prescription and discussed this patient and the reason for the prescription. However, you did not record the discussion you had with the prescribing physician, which was one of the failings of your documentation.

In light of this, the panel determined that on the balance of probabilities, it is more likely than not that, you did not record the discussion you had with a clinician when you added a prescription for metformin for Patient 12. The panel, therefore, finds this charge proved.

Charge 1(b)(ix)(a)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    b. failed to follow safe prescribing practice in that you:

        ix. On or around 29 March 2018 in relation to Patient 15, re-authorized warfarin:

            a) without discussing and/or recording a discussion with a prescribing clinician;

This charge is found partially proved – Did not record but did have discussion.

In reaching this decision, the panel took into account your evidence.

You told the panel that the prescription was issued after the doctor had a conversation with you and signed the prescription. You said that in relation to this re authorisation you discussed matters with the doctor, you did not record that conversation anywhere in the notes.

There was no evidence before the panel which suggests that you did not have a discussion with a prescribing clinician when reauthorising warfarin for Patient 15. However, it noted that you admitted to the panel that you did not record that discussion. In light of this, the panel determined that on the balance of probabilities, it is more likely than not that, you did have that discussion but did not record the discussion within the notes. The panel, therefore, finds this charge proved.

Charges 1(b)(xi)(a), (b), (c)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    b. failed to follow safe prescribing practice in that you:

    xi. On or around 19 April 2018 recorded a consultation with Patient 18 regarding a depo provera injection and did not discuss and/or record a discussion with the patient about:

        a) The importance of the timing of the injection
        b) Risk of pregnancy
        c) Current contraception

These charges are found proved.

In reaching this decision, the panel took into account the documentary and supplementary evidence of Witness 4 which included the documentary records relating to Patient 18. The panel also took into account the evidence provided by you.

Witness 4 in her witness statement:

> ’68. […] *Patient 18 had attended a consultation with the registrant regarding a depo provera ("depo") injection which is a contraceptive injection. The drug license for the depo injection states it has to be given within 12 weeks and 5 days of the previous injection. If you go outside this window the contraceptive protection is potentially not effective and can lead to pregnancy. If the first injection is given within the first five days of a woman's period they are immediately protected from pregnancy. If the injection is given on the sixth day or later the patient would need to take extra*

precautions such as not having sex or using a condom. If a patient is seen outside these parameters a nurse would need to advise the patient to take these precautions.

69. Once a medication has been issued from our stock we issue a prescription for it. After previous conversations with the registrant about documentation she had sent me a task to make a prescription for Patient 18 I spoke to her to say that there was nothing at all in the notes to say that the patient had received the injection before or when her last menstrual period was. There was no recording of discussions regarding current contraception or risk of pregnancy; and no recorded discussion regarding extra precautions if the injection had not been issued within the first five days of her menstrual cycle. She reassured me that the patient had had the injection previously at the sexual health clinic and that the injection she had given was in date but there was no documentation to that effect in the record. I reminded her about the importance of documentation. She told me that she did document which I accepted but countered that as demonstrated in this case she clearly did not do it all the time.

70. I'm not aware of any patient harm however, there were risks involved in the registrant's recording of the consultation. If the registrant had given the depo injection outside the 12 week window, the patient could have become pregnant and this could have gone undetected. If undetected the patient may not have had the opportunity to terminate the pregnancy if they wanted; they would have had no antenatal care; and may not have made the changes to their lifestyle that would be advised to someone who was pregnant, including stopping smoking, drinking or drug taking. At this point, with all of the previous issues and discussion I would have expected the registrant to have almost been paranoid about making mistakes and possibly recorded more information than she needed to. I would not have expected her to have kept making the same mistakes.'

The panel had sight of Patient 18's documentary record which was a consultation information sheet regarding a consultation carried out by you with Patient 18 on 19 April 2018. This document also contained amendments made following Witness 4's discussions

with you; a screenshot of your initial entry in the patient's consultation record; and a screenshot of Witness 4's correspondence with you via SystmOne.

The panel noted that Patient 18 had told you that she was given the depo injection previously at a health clinic. However, there was no evidence of this on SystmOne. There was no evidence before the panel which demonstrates a recording of what was discussed with Patient 18 about the provera injection. It noted that you originally entered:

'H:Attended for depo-provera injection,
Given in LOQ,
Bn:A75688 exp:05/2020,
States feels well,
No depo/general problems/contra-indications currently evident,
All options/possible red flags discussed,
To re vprn,
Adv given,
TRIN/111 service.'

However, there is no recording on the importance of the timing of administering the injection, the risk of pregnancy or any discussion on Patient 18's current contraception.

The panel, therefore, determined that on the balance of probabilities, it is more likely than not that, you did not discuss the importance of the timing of administering the injection, the risk of pregnancy or any discussion on Patient 18's current contraception and did not record that discussion. The panel, therefore, finds these charges proved.

Charge 1(c)(i)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    c. *Failed to complete an asthma review appropriately for Patient 3 in that you:*

        i. *Did not conduct a medication review;*

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and supplementary evidence of Patient 3 and in particular paragraph 7 of their witness statement, which states:

> *7. I have had asthma for a long time so I know what to expect and I know what questions are asked. The registrant measured my peak flow which is where you take a deep breath and blow into a device which is then repeated a further two times. The best or average reading is then taken which indicates whether you have asthma. She also told me to eat a high fibre, low fat, low salt diet which is something I have never been told before during an asthma review. She did test my inhaler technique. That was about the extent of the review. She did not ask me about my symptoms and how I felt my asthma was being controlled. She did not check my medication. I was having issues with my asthma at the time which included slight breathlessness and having to increase my asthma medication. I usually have issues around September/October. She definitely did not give me an asthma plan nor did she go through one with me.'*

In her written evidence, patient 3 confirmed that you tested her inhaler technique. In patient 3's oral evidence she stated, *"she did test my inhaler technique".*

During the course of your evidence, you were asked what does a medication review entail.

'You stated that the medication review entails which inhalers are prescribed.'

The NMC did not adduce any evidence to the contrary and the panel was therefore satisfied that a medication review had been undertaken.

The panel noted from Witness 4's witness statement:

> *84. At an asthma review as a minimum there should be a discussion about the symptoms and how well the patient feels it is controlled. The nurse should also conduct a review of the medicines, check the patient's peak flow by getting the patient to blow into a device, check the patient's inhaler technique using the device and issue an asthma action plan. The action plan says what the treatment is, how to recognise when asthma is not as well controlled and how to deal with an asthma attack and a copy is offered to the patient. The nurse issuing the asthma plan should go through this with the patient. After this initial complaint and after subsequently seeing other asthma patients I had concerns around the asthma reviews conducted by the registrant.*

The panel was of the view that, checking the patient's inhaler technique constituted a medication review and as such found the charge not proved.

Charge 1(c)(ii)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

   c. Failed to complete an asthma review appropriately for Patient 3 in that you:

ii. Did not give an asthma plan to Patient.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and supplementary evidence of Patient 3 and Witness 4.

The panel noted from Witness 4's witness statement:

> *'82. On 29 January 2018 Patient 3 called to say she wanted to informally draw my attention to her dissatisfaction with her encounters with the registrant… She also said that the asthma review conducted took three minutes when the letter she received said it should have taken 20. When asked whether she received an asthma action plan she said that she had not…*
>
> […]
>
> *84. At an asthma review as a minimum there should be a discussion about the symptoms and how well the patient feels it is controlled. The nurse should also conduct a review of the medicines, check the patient's peak flow by getting the patient to blow into a device, check the patient's inhaler technique using the device and issue an asthma action plan. The action plan says what the treatment is, how to recognise when asthma is not as well controlled and how to deal with an asthma attack and a copy is offered to the patient. The nurse issuing the asthma plan should go through this with the patient. After this initial complaint and after subsequently seeing other asthma patients I had concerns around the asthma reviews conducted by the registrant.*
>
> *…*

87. […] *record was accessed by the registrant at 14:22 and the record was closed at 14:29 meaning the consultation lasted seven minutes. I do not feel that the registrant could have done a good review in this time. She had recorded that she had done a number of things and seven minutes is probably not long enough to have done them all. She has recorded that she had done a medicines review and the registrant has recorded that Patient 3 was not having any issues when Patient 3 had told me that her medicines had not been checked. Had the registrant asked Patient 3 how her asthma was she could have told her the issues she was having.'*

The panel also noted from Patient 3's witness statement:

'6. My second consultation with the registrant was for an asthma review. I had received a letter from the surgery advising that the review would take 20 minutes however, I was in and out within three. I know that it was only three minutes because I checked the time on my watch when I went in. The consultation was over so quickly that when I came out I looked at my watch again and saw that I had been in the room for three minutes.'

During your evidence, you told the panel that you had a blank asthma plan, so you filled it out and you gave it to the patient, but this was not one that you had downloaded off the computer. You said that:

'The plan was a traffic light system. It is green, yellow, then red. It goes from left to right, left being the green. You write on it how many puffs of the Ventolin that the patient can use in terms of being out of breath. Also, you write on it if they need to increase their steroid inhaler. Then the orange is if things become urgent and signposted where to go, to who to speak to, who to be seen by. Then the red was basically the advice to ring 999. They can have a mini nebuliser, which is so many puffs of the Ventolin inhaler into a plastic chamber and then they inhale these puffs of it is all in one plastic chamber and that gives them a mini nebuliser to buy them

some time so the airways in the lungs will open enough because with an asthma episode everything shuts up and it gets filled with saliva and fluid.'

The panel took into account Witness 4's notes on Patient 3's complaints:

'When asked if she was given an asthma action plan she states not and also when asked states medication was not checked with her which she says wasn't great as she was having some problems with her asthma at the moment (declined my offer today of follow up appointment with another nurse)'

The panel preferred the evidence of Patient 3 as it was of the view that Patient 3 was credible on this issue. Therefore, the panel was satisfied that, in the absence of any additional evidence and on the balance of probabilities, you did not give an asthma plan to Patient 3.

Charge 1(c)(iii)

That you,

1. *during your employment with Chapel Street Medical Centre between December 2017 – May 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    c. *Failed to complete an asthma review appropriately for Patient 3 in that you:*

        iii. *Demonstrated poor infection control in that your uniform was not clean*

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient 3 witness statement and oral evidence, and Witness 4's witness statement and the evidence provided by you.

The panel noted from Patient 3's witness statement:

'*8. I noted during the consultation that the registrant's uniform was dirty. She had dirty white marks on her tunic and her trousers which were linen* […]*'*

The panel took into account Patient 3's oral evidence:

'She had a lot of white marks all over her yuan form, all over her tunic and all over her trousers because it is a dark uniform so you pick up the white quite clearly.

[…]

Because of the dirt on the uniform it made me look at her trousers, which I thought were jeans initially, but on closer inspection I could see they were linen. Dark tunic, which is the dark nurse's uniform, the linen trousers and animal print dolly shoes. No socks or tights.'

The panel also noted from Witness 4's witness statement:

'[…] *She said that the registrant's uniform was dirty* […]'

The panel noted that during the course of your evidence, when questioned about white marks on your uniform, you stated:

"that is absolutely not true, I have always always always taken pride in my appearance"

The panel therefore heard conflicting evidence on this particular issue but was of the view even if there was white marks on your tunic, that does not necessarily constitute poor infection control. The panel therefore find this charge not proved.

Charge 2(b)

That you,

2. *during your employment with Oakhill Medical Practice between 15 August 2018 – July 2019 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows:*

    b. *Did not demonstrate safe infection prevention and control in that you disposed of bloodied cotton wool and/or used syringes in the general waste bin on or around 9 May 2019*

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 2, Witness 5 and your oral evidence.

The panel took into account Witness 2 written evidence:

> *‘17. Used syringes should be put in the designated yellow 'burn bins' provided in every clinical room. General waste is collected in standard household plastic rubbish sacks easily pierced by sharp objects such as syringes. The risk is of a 'needle stick injury' with a syringe that is contaminated and the associated risk is blood borne infections such as Hepatitis B, HIV etc.*
>
> *18. Once finished with, bloodied cotton wool should be put in the yellow clinical waste bin only, again provided in every clinical room in the Practice. General waste bins go to landfill sites and should not contain hazardous waste such as blood contaminated materials. This is basic infection control as the waste materials pose an infection risk to anyone handling the waste.’*

In Witness 5’s witness statement:

‘21. On 9 May 2019 eight items containing patient information were found in the general waste bin in treatment room two. The registrant had worked in the room the previous day and the items found belonged to patients that had been seen by her the day before. All items for patients ordered by the practice from the pharmacy are packaged in boxes which are labelled with patient details including their name, date of birth and NHS number. The registrant had removed the packaging, administered the injection or item and then disposed of the packaging containing the patient identifiable information in the general waste bin.

22. Each room has a clinical waste bin in which all clinical waste should be put. There are also two confidential waste bins in the practice in which all confidential waste needs to be disposed of. Any items that have come from the pharmacy that have patient identifiable information on them should be placed in the confidential waste bin. I would have expected the registrant to have put them to one side and placed them in one of the confidential waste bins. At the time the practice did not have a policy that sets out the process for destroying confidential waste but I would expect that a nurse of the registrant's experience to know this.

23. Not disposing of items containing confidential information in the correct way can lead to a breach of confidentiality. As a practice we have promised our patients that we will safeguard their private information. If it goes in a general waste bin, the bin bag could split and the information could end up as general waste in the street.

24. The issues had been brought to my attention by [Mr 7] *who had seen the contents of the bin. I went into the room and spoke to the registrant directly.* […] *She did not deny putting the bloodied cotton wool and the syringes in the general waste bin. She told me that it was okay to put some items like this in general waste, I explained that it is not.’*

The panel had sight of the Practice’s Policy for Clinical Waste.

The panel noted from Witness 5's oral evidence:

> *'I said there is bloodied cotton wool in the general waste bin and she did not seem to think it mattered. She thought it was all right to put some things, which is clearly clinical waste, in a general waste bin.*
>
> *I cannot actually remember seeing syringes. I remember the dressing (unclear), but as I say it is a long time ago.'*

The panel also noted that Witness 5 did not actually know who put the cotton wool in the bin. She told the panel:

> *'No, but obviously I spoke to Maria at the time and she did not deny putting it in.'*

You told the panel:

> *'I have been in care and nursing for nearly 39 years this year and I can safely say that I have never, never disposed of any body fluids on gauzes or cotton wool or paper towel on the examination couches, anything, in the wrong plastic bag or bin bag.'*

When asked by Mr Buxton about used syringes, you said you never put used syringes in a plastic bag or a bin bag.

The panel noted that the room was used by many people, and there is no direct evidence from any witnesses to confirm that it was you who disposed of bloodied cotton wool and/or used syringes in the general waste bin on or around 9 May 2019. The panel therefore finds this charge not proved.

Charge 2(c)(i)

That you,

2. *during your employment with Oakhill Medical Practice between 15 August 2018 – July 2019 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows:*

    c. *Did not keep accurate records in that you:*

        i. *On 22 May 2019 carried out a consultation with Patient 24 and did not make a record of the consultation in the patient notes*

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary, supplementary and oral evidence of Witness 5, which included the appointment book dated 22 May 2019 which shows evidence of Patient 24's arrival and Patient 24's consultation record. The panel also took into account the evidence provided by you.

The panel noted that the appointment book dated 22 May 2019 shows that the Patient did arrive for a scheduled appointment. However, the details of that appointment were not recorded within SystmOne, which you should have done. This was not a requirement of you but it was considered to be best practice.

On Patient 24's consultation record, the panel noted that under *'Mon 20 May 2019…'*, it stated:

'Seen in hospital anticoagulation clinic …'

The panel took into account the oral evidence from Witness 5 in which she told the panel:

'[…] *It is likely Patient 24 did not attend because they had been at the hospital two days before, or it could have been because they was clearly up and down with the INR, unstable, that they decided to monitor them more closely. I could see either*.'

In response to Mr James, as to what Witness 5 would expect to see if Patient 24 was seen on 22 May 2019 in the consultation notes from SystmOne, she said that:

'Well, I would expect there to be an entry dated Monday 22nd May with Maria's name and some notes about what she did.'

In your oral evidence on 27 October 2022, in response to Mr Buxton's question on an appoint in your diary for 22 May, you said that:

'I will be honest with you, it is a very long time but I cannot remember seeing this patient.

[…]

I will be honest with you, I cannot recall.'

The panel was content that Patient 24 attended an appointment on 20 May 2019, in which they had an INR before the scheduled appointment on 22 May 2019. The panel were content that the patient attended the surgery on 22 May 2019 as scheduled, but on the balance of probabilities the patient was not seen as there was no need to have that appointment. The panel noted that it would not be normal practice to repeat an INR test after two days.

In light of the above, the panel determined that on the balance of probabilities, it is more likely than not that, an appointment was made for Patient 24 but that this consultation did not take place. The panel, therefore, did not find this charge proved.

Charge 2(c)(ii)

That you,

1. *during your employment with Oakhill Medical Practice between 15 August 2018 – July 2019 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows:*

    c. *Did not keep accurate records in that you:*

        ii. *On 24 June 2019 following a consultation with Patient 23 recorded an incorrect INR result and recorded the colour of the tablet instead of the dosage*

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary, supplementary and oral evidence of Witness 2 and Witness 5. The panel also took into account Patient 23's consultation record and the documentary and oral evidence provided by you.

Recorded incorrect INR result:
The panel noted that you deny inputting 9.40 as the INR result.

The panel noted from Patient 23's consultation record under *'Friday 14 June 2019 Maria D':*

> *'Appt made for Wednesday 24/06/19,*
> *to avoid confusion – patien tto alternate x4 brown tablets with x5 brown tablets – til is reviewed on Wednesday,*
> *states missed tablets on 10/06/19,*
> […]'

The panel heard evidence from Witness 2:

'Q. Yes. 9.40 is the appointment time.
A. Yes. That is Witness 5's writing, our practice manager.

Q. Right. Okay. Do you notice, doctor, that if you look at the last line in the grid on the treatment record -- and I am following along from in the left-hand column 24/6/19, and then within that row we see a series of days and "four brown". The left-hand cell and then moving across the number 9.40, do you agree -- you are not an expert so I am just asking you to tell me if you agree with this -- the thickness of the writing and the perhaps pressure, it is hard to say from a photocopy, is the same for the 24/6/19 as the ones the other side of the 9.40. In other words, does the 9.40 to you look as if it is written in a different pen?
A. Yes, it does.'

The panel also heard from Witness 5:

'Again, you say: "She has recorded the time of the appointment in the INR box and has again referred to the dosage by the colour of the tablets rather than in milligrams". Do you know what should have been written in the various boxes?
A. Well, yes. In the INR column it should record what the INR was at the time and we would normally put the grams of Warfarin rather than the colour of the tablet.

Q. Looking at the bottom of that exhibit there is some handwriting. Can you tell us whose handwriting that is?
A. That is mine.

Q. It says: "9.40 is the appointment time

Q. I see. That "9.40" in the INR column is not that is not Maria's writing is it?
A. It does not look the same as the other writing. The "4" is quite different.

Q. On instructions, just to make it plain this is my case on behalf of Maria, that 9.40, under the INR column, has not been written by her. I think, to summarise, your evidence is that is not Maria's writing. It looks different, am I right?
A. I would agree.'

On the balance of probabilities, the panel was satisfied that the reference to 9.40 was not written by you and it was not an INR score.

<u>Recorded the colour of the tablet instead of the dosage:</u>

Witness 2 in his oral evidence told the panel the following:

'Q. In terms of the issue of the colour of the tablets, you quite fairly said that when you were asked by Mr. James about this -- I am summarising, in a sense -- depending on the patient, if you have a patient who has been on Warfarin for a number of years and is very used to and accustomed to the drugs he or she may themselves refer to them as tablets by colour. Would you agree?
A. Agreed.

Q. In any event we know that there are varying colours of tablets and patients, particularly those familiar with the Warfarin regime will know about the different colours. That is understood, is it not?
A. I would expect so, yes.'

The panel noted that during your oral evidence, you said that you check with patients as to the colour of the medication, which demonstrates that your practice is to write the colour of the tablets.

In light of your evidence and Witness 2, the panel conclude that you kept an accurate record of the colour of the tablets and therefore the panel finds this charge not proved.

Charge 3(a)(vii)

That you,

2. *during your employment with Ashfield House Surgery 1 October 2018-27 January 2020 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

    a. *did not keep accurate records when you:*
        a. *Recorded the incorrect manufacturer on influenza vaccination records for Patients 39, 40 and 41.*

This charge is found NOT proved.

The panel had sight of the three consultation sheets, where you recorded Fluarix Tetra (GSK) as the vaccine which was administered to Patients 39, 40 and 41. The panel had further regard to the written statement of Witness 3, in particular:

> *'The registrant had selected Fluarix (GSK) rather than Fluad (sequirus). Fluarix (GSK) is not only the wrong manufacturer, it is an obsolete vaccine. When*

challenged she failed to understand the correct procedure and stated, "It was still a flu vac"".

However, in oral evidence Witness 3 was asked if vaccines were loaned out to other surgeries and she responded *'That is a difficult one. Probably if the surgery had run out. It is standard practice to assist local practices and vice versa. We have got reciprocal arrangement; all GP practices have. It may happen once a year, once every five years; it is very rare'.*

In relation to the question who is responsible for auditing the stock of flu vaccines in the fridge, Witness 3 stated *'Again, the nurses. So that was mainly the HCA and someone from admin.'* Witness 3 further confirmed in her oral evidence *'they probably were not audited until we looked at recouping the money because they were in the surgery just a short time. They were all given within a month, normally. But any vaccine that was audited, we would just check the batches and make sure that none had expired, made sure that they were not touching the sides of the fridge. It was basic practice.'*

Given that Witness 3 was not involved in auditing the vaccines, it is possible that in the reciprocal arrangements with other surgeries, there could have been a different vaccine in the fridge. Furthermore, the panel considered that your explanation of what had happened could be correct.

The NMC did not provide the panel with an audit of what vaccines were in the fridge, so on the balance of probabilities the panel determined that the charge is not found proved.

Charge 3(c)(i)

That you,

3. *during your employment with Ashfield House Surgery 1 October 2018-27 January 2020 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows*

   c. Did not follow safe infection prevention control in that, on 9 September 2019, you:

   i. Did not wash your hands before starting, or in between patient consultations

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and supplementary evidence of Witness 3, which included the Surgery's policies and your disciplinary letter dated 9 September 2019. The panel also took into account the evidence provided by you.

The panel noted from Witness 3's witness statement:

> *'36. I started work before the registrant and she did not wash her hands before starting the clinic. She took two smears, followed by an ear syringing and then two further smears. She then administered two travel vaccinations, a blood test and then two more travel vaccinations. She used fresh latex gloves for each smear but failed to wash her hands at all during the entire morning clinic. This showed a total disregard for infection control guidelines set out by the practice.* […]
>
> *37. The registrant should have washed her hands before she started the clinic, after taking off latex gloves and before and after having touched a person/performed a procedure. It was imperative for her to do this to prevent potential transmission of infection between patients. She had completed the infection control training module on 9 July 2019 so would have been aware of this.* […]'

In response to Mr Buxton, Witness 3 told the panel that discussions took place due to significant concerns about infection control. She said that the discussions were about handwashing which had to be addressed that day. She told the panel:

> *'I nearly stopped her after the first time she did not wash her hands and I felt guilty that I did not, but I needed to see was she going to wash her hands later on, and she never did. I had to fight with myself. I have got high standards. I thought one day did not matter because if that is her practice for the whole of her career we need to be aware of that. After latex gloves, touching patients prior to and after injections, not one hand wash the whole day. That is what I was appalled at.'*

However, the panel noted that Witness 3 had left you to carry on working that day unsupervised as after the meeting, you had assured Witness 3 that you would wash your hands.

The panel had sight of the Surgery's Biological Substances Infection Control protocol and the Surgery's Infection Prevention and Control protocol. The panel also had sight of your infection prevention and control certificate and the outcome of the disciplinary letter dated 9 September 2019.

The panel also took into account your oral evidence. You said that you used the gel. You said that you wash your hands at the beginning of each shift but use the gel thereafter. You said that the gel can be used four times before having to wash your hands again, which is what you did unless 'it is claggy', in which you would wash your hands.

The panel had sight of the Surgery's infection prevention and control protocol:

> ***'Contraindications***
> *There should be no contraindications preventing staff from carrying out effective hand hygiene practice within the practice. The practice must provide adequate hand hygiene facilities at the point of care, with designated hand wash basins, wall*

mounted single cartridge dispensed liquid soap, wall mounted dispenser paper towels and alcohol hand rub.'

The panel also had sight of the NHS National Patient Safety Agency's policy on 'Hand Cleaning Techniques'. This does not state as to whether washing or using the gel is better. Further, the panel has not been told as to what 'Safe Prevention Infection Control' is.

The panel had sight of the meeting notes dated 9 September 2019. However, the panel was of the view that there was nothing contemporaneous in those meeting notes, as the letter was vague and did not include anything about handwashing. This did not define what 'safe prevention infection control' is either. In light of this, the panel could not be satisfied that there has been a breach. Therefore, the panel finds this charge not proved.

Charge 3(c)(ii)

That you,

3. during your employment with Ashfield House Surgery 1 October 2018-27 January 2020 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a practice nurse as follows

c. Did not follow safe infection prevention control in that, on 9 September 2019, you:

ii. Placed used syringes on a desk rather than dispose of them in the sharps bin

This charge is found NOT proved.

The panel had regard to the witness statement of Witness 3 and in particular paragraphs 32 and 38:

‘32. On 9 September 2019, I supervised the registrant in practice. I produce my record of the supervision as exhibit JR/25. This includes reference to three other supervisions carried out on 9 September 2019, 27 September 2019 and 3 October 2019 and a telephone conversation had with the registrant on 30 October 2019.

…

38. On two occasions the registrant administered travel vaccinations and placed used sharps on the desk at the side of the sharps bin rather than placing them immediately into the sharps bin which was right next to her. This presented a risk of needle stick injury either to herself or to the patient. Also, if the patient has blood born infection, it could have passed onto the registrant via a needle stick injury.’

However, when the panel considered JR/25, it noted that there is no reference to sharps in that record. The panel also considered JR/30, which is a final written warning dated 9 September 2019, the very day the incident was alleged to have occurred. This letter refers to unrelated matter and does not mention sharps at all.

Further, the panel noted that you deny placing used syringes on a desk rather than dispose of them in the sharps bin. Given the lack of contemporaneous documentary evidence in support of Witness 3’s evidence, the panel was not satisfied on the balance of probabilities that this charge had been proved.

Charge 4(a)

That you, a registered nurse;

4. Failed to complete an asthma review appropriately for Patient 3 in that you;

a. Documented that you had completed a medication check when you had not;

This charge is found NOT proved.

Having found charge 1(c)(i) not proven it follows that this charge falls away.

Charge 4(b)

That you, a registered nurse;

4. *Failed to complete an asthma review appropriately for Patient 3 in that you;*

    b. *Documented that you had given the patient an asthma action plan when you had not;*

This charge is found proved.

Given the panel's determination in Charge 1(c)(ii) and the documentation at exhibit AH/3, which states an action plan was provided, it follows that this charge is also found proved.

Charge 5

That you, a registered nurse;

5. *Your actions as set out in charges 4a and/or 4b above were dishonest in that you sought to conceal the fact that you had not carried out those actions;*

This charge is found proved in relation to Charge 4b only.

Following the panel's determination in respect to charge 4a, this element of charge 5 falls away.

In respect of charge 4b.

In considering whether your 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 also took into account the NMC Guidance document 'Making decisions on dishonesty charges DMA-6.'

The panel found that you did not give an asthma action plan to Patient 3, therefore your actual state of belief and knowledge was that you had not given this document to the patient. By confirming you had in the patient record, you were in essence falsifying the record to show something you had not done.

The panel next considered whether your conduct would be regarded as honest or dishonest by the objective standards of 'ordinary decent people'. The panel concluded that it was dishonest by these standards.

The panel therefore found your actions at charge 4(b) to be dishonest. This charge is therefore found proved.

Charge 6(b) & 6(c)

That you, a registered nurse;

6. *Breached patient confidentiality in that:*

b. *On or around 9 May and 20 June 2019, you disposed of items containing patient identifiable information ('PII') in the general waste bin*
c. *On or around 20 June 2019, you disposed of prescriptions containing patient identifiable information ('PII') in the general waste bin*

These charges are found NOT proved.

In reaching this decision, the panel took into account the documentary and supplementary evidence of Witness 5 and the evidence you provided.

<u>9 May and 20 June 2019 – disposing items containing PII:</u>

During Witness 5's live evidence, she told the panel that she became aware of the eight items containing patient information were found in the general waste bin after she was told by Mr 7, who did not give evidence to the panel and, allegedly used the room the following day. She said that:

> *'*[…] *putting patients details in a general waste bin is breach of the practice policy. Any patient identifiers have to be disposed of in a cross cutting shredder so I think I raised it with Maria.'*

Witness 5 also told the panel that she does not remember if she went to look at the bin, or the bin was brought to her, but that she saw the things within the bin. However, she could not *'quite remember if I saw it in the bin or if the box and packaging containing the patient identifiers were brought'* to her.

The panel noted from Witness 5's witness statement:

> *'24. The issues had been brought to my attention by [Mr 7] who had seen the contents of the bin. I went into the room and spoke to the registrant directly. She admitted that she had put the patients identifiable information in the general waste*

bin and seemed to understand that in terms of information governance and the CQC that all patients identifiable information must be destroyed in cross cutting shredders. […] *She told me that it was okay to put some items like this in general waste, I explained that it is not.'*

You told the panel in your live evidence:

'First of all, my room was not treatment, it was an office. Secondly, the average wastepaper basket is - whether it is two and a half feet, two feet tall. There was not the volume there to put eight pieces of identifying packages in there. I have never never, in my now 39 years' experience, ever thrown away any patient identifying markers anywhere in any colour bin.

I rip the side off with the patient identifying markers and put them into the shredding box in reception.'

You also told the panel that you *'absolutely categorically'* do not agree that you admitted to Witness 5 putting the PII in the general waste bin. You said that:

'She is wrong. I never, never put anything hazardous waste or anything in the black bagged bin in my room, in my consultation room.'

<u>20 June 2019 – disposing of prescriptions:</u>

In response to Mr James, Witness 5 told the panel that she was not able to expand on a similar incident that took place on 20 June 2019 where prescriptions containing patient identifiable information were found in the general waste bin in room 2 that you worked in the room the day before and the confidential information relates to patients you had seen the previous day.

The panel was of the view that there is no documentary evidence or corroborating evidence for these incidents that took place on 9 May and 20 June 2019 concerning the disposal of PII and prescriptions. The panel was also of the view that Witness 5's evidence regarding the PII was hearsay, as she was not a direct witness to this incident, and consequently, her evidence was lacking in detail. The panel put little weight on Witness 5's evidence as it was hearsay. Furthermore, it noted that the investigating team did not speak to Mr 7 and that Mr 7 and you were having disagreements at the time.
On the balance of probabilities the panel found these charges not proved.

Charge 7

That you, a registered nurse;

6. *On or around 7 October 2019 retrospectively amended the records for Patient 26's appointment on 4 June 2019 to indicate that you had checked the demographics on the specimen bottle and form with the receptionist when you had not.*

This charge is found NOT proved.

In reaching this decision, the panel took into the documentary and supplementary evidence of Witness 5, which included the SystmOne record for Patient 26 dated 4 June 2019, and the evidence you provided. The panel also had sight of the 'Screening Incident Assessment Form' dated March 2017.

In Witness 5's witness statement, she wrote:

> *'40. On 7 October 2019, I met with the registrant and discussed the errors regarding labelling of specimens. This was an investigative meeting purely to discover how the significant error had arisen. I have been unable to find a written record of this meeting to exhibit. It was agreed that going forward all cervical screening forms and pots were to be second checked by a second person to*

ensure all relevant identifiers were present on both the form and the pot. The second person would also input the read code (XaXmW - Patient Identity Verified) into the patient's records on SystmOne in their own name and the entry is automatically time and date stamped.'

Witness 5, during her oral evidence, told the panel that she was not sure if Ms 8 was on annual leave on this particular day.

The panel had sight of the screenshot of Patient 26's SystmOne record. The original entry was entered by you on 4 June 2019 and amended by you on 7 October 2019, which states '*amended by: Nurse Maria Demetriou (Nurse Access Role) on 07 October 2019 16:51'*. The panel noted that the screenshot does not show the details of the amended entry.

During your oral evidence, you denied that an investigative meeting took place and claimed that you had checked the demographics on the specimen bottle and form with Ms 8.

The panel did not have evidence before it which demonstrated that Ms 8 was not working on that day, and therefore it was not satisfied that you did not perform the check with Ms 8. Further, there was no record of the investigative meeting that allegedly took place between Witness 5 and you on 7 October 2019. Accordingly, the panel could not be satisfied that this meeting took place.

In light of the above, the panel did not find this charge proved.

Charge 8

That you, a registered nurse;

8. *Your actions in charge 7 were dishonest in that you sought to hide the fact that you had not checked the details*

This charge is found NOT proved.

As charge 7 is found not proved, this charge falls away.

Fitness to practise

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

Submissions on lack of competence

The NMC has defined a lack of competence as:

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

Mr James invited the panel to take the view that the facts found proved for charge 1 and 3 amount to a lack of competence. The panel had regard to the terms of ''The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision.

Mr James identified the specific, relevant standards where your actions amounted to a lack of competence. Mr James submitted that lack of competency needs to be assessed using a three stage process:

- Is there evidence that you were made aware of the issues around your competence?
- Is there evidence that you were given the opportunity to improve?
- Is there evidence of further assessment?

Mr James submitted that your failures were serious and occurred over a significant period of time in two separate practices, such failures included not making accurate records, not following medication protocols or not making asthma reviews. Mr James further submitted that your failures amounted to an exceptionally low standard of practice and that the charges found proved at 1 and 3 represent a fair sample of your work.

Mr Buxton submitted that the concerns occurred over a two-year period whilst you were working at two GP practices. He emphasised that the working environment was

pressurised, the atmosphere was stressful and you were unhappy. He also informed the panel of external factors of your personal life that added to the stress you were dealing with at work.

Mr Buxton submitted that during this period you discussed issues with patients and the doctors but did not always record those discussions. Mr Buxton also submitted that you are knowledgeable and have displayed knowledge over the years of prescribing medication. Mr Buxton further submitted that you acknowledge that you made errors, one of which resulted in you falsifying one action on a record. He submitted that you understand the impact your actions had on colleagues, patients and the nursing profession.

Submissions on misconduct

Mr James invited the panel to have 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.'*

Mr James invited the panel to take the view that the facts found proved amount to misconduct. **'**The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr James identified the specific, relevant standards where your actions amounted to misconduct. Mr James referred the panel to charges 4b, 5 and 6a and submitted that your actions amounted to misconduct.

Mr James submitted that your failures at charge 4b which involved you falsifying records amounts to misconduct. He emphasised that record keeping is an important part of nursing skills and practice, so falsifying records does fall below nursing standards. Mr

James further submitted that the dishonesty that arises from this charge can lead to harm to patients. He referred to the NMC Code 20.2 which states:

> *'Act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.'*

Mr James submitted that charge 6a, which involved you breaching internal confidentiality policy, does undermine NMC Code 5 which states:

> *'Respect people's right to privacy and confidentiality*
> *As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.'*

Mr James submitted that it is for the panel's professional judgement to decide whether your actions at charge 6a was a departure from the standards of conduct.

Mr Buxton submitted that your conduct at charge 6a was a serious breach of privacy and confidentiality. He further submitted that you made reflections on this incident and explained how it occurred, simply that it was a mistake and that you have shown remorse. Mr Buxton submitted that there is no risk of repetition as there is no indication that it will happen again.

Submissions on impairment

Mr James 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).

Mr James submitted that you cannot practise safely without restriction based on the charges found proved.

Mr James submitted that you have acknowledged your failings and made admissions from the outset. However, the concerns raised are of a serious nature that may have an impact on patients.

Mr James submitted that there is a risk of repetition as the incidents occurred over a period of years and three separate referrals. He further submitted that the dishonesty element brings the profession into disrepute.

Mr James invited the panel to find that you are currently impaired.

Mr Buxton submitted that during the period the incidents occurred, you believed that you lacked assertiveness in communicating with colleagues and being proactive with patients, however, since then you have undertaken and completed an assertiveness course.

Mr Buxton informed the panel that you are currently working as a healthcare support worker and you have not practised clinically for a number of years. He also outlined to the panel that you have been subject to suspension since 2020 and your nursing skills have not been tested since then. He further informed the panel that your current employer is unaware of your interim suspension order.

Mr Buxton submitted that you have reflected and recognised the impact your actions had on the profession, colleagues and patients. He submitted that you have undertaken and completed training courses to remedy the deficiencies.

Mr Buxton submitted that even though you have not tested your clinical skills, you have nonetheless kept up with your learning, skills and work relevant to the profession. Mr Buxton further submitted that the dishonesty falls at the bottom of the range of seriousness for dishonesty and the context should be taken into consideration.

Mr Buxton submitted that a finding of impairment on public interest grounds was not required in your case.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Grant, Cohen v GMC [2007] EWHC 581 and Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Decision and reasons on lack of competence

The panel had regard to the NMC guidance FTP-2B in relation to lack of competence.

'Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk.'

When determining whether the facts found proved in charges 1 and 3 amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

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

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

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:

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

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

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

To achieve this, you must:

18.1. prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs'

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonably competent registered nurse and not by any higher or more demanding standard.

The panel was of the view that the charges cover a range of recording issues, which include failing to communicate with colleagues, prescribing failures as well as mislabelling samples. The panel determined that these issues may involve patient harm or put patients at risk of harm.

The panel looked at a range of your clinical work and concluded that you have failed to meet the standards of the Code due to your inadequate standard of performance.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that your practice was below the standard that one would expect of a reasonably competent registered nurse.

In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

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 Code sets the professional standards of practice and behaviour for nurses, midwives and nursing associates, and the standards that patients and public tell us they expect from nurses, midwives and nursing associates. While the values and principles can be interpreted for particular practice settings, they are not negotiable.

The panel was of the view that your actions at charges 4b, 5 and 6a did fall significantly short of the standards expected of a competent registered nurse, and that your actions amounted to a breach of the Code. Specifically:

5. ***Respect people's right to privacy and confidentiality***
   As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.'
   To achieve this, you must:
   5.1. respect a person's right to privacy in all aspects of their care

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.*

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the concerns raised in charges 4b, 5 and 6 were serious.

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 lack of competence and misconduct, your 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/their fitness to practise is impaired in the sense that S/He/They:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

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

The panel found that patients were put at risk of harm as a result of your lack of competence and misconduct. Your lack of competence and misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty seriously.

The panel also had regard to the NMC updated guidance on impairment DMA-1, last updated 27 March 2023.

Regarding insight, the panel considered that you have shown a good level of insight by demonstrating an understanding of how your actions put patients at a risk of harm and how this impacted negatively on your colleagues and the reputation of the nursing profession.

In its consideration of whether you have taken steps to strengthen your practice, the panel took into account the relevant training you have undertaken and your detailed reflective piece. The panel determined that the concerns raised are remediable, but you have not demonstrated full remediation in that the training was somewhat limited in scope and duration. Furthermore, the panel would have been assisted by references from colleagues or your current employer to attest to your character and your performance at work.

The panel is of the view that there is a risk of repetition based on insufficient evidence to suggest that the risk has reduced. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that, in this case, a finding of impairment on public interest grounds was required, particularly in view of the finding of dishonesty.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. 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.

Submissions on sanction

Mr James invited the panel to impose a suspension order, as the panel has found your fitness to practise currently impaired.

Mr James outlined the aggravating and mitigating features in your case.

Aggravating

a. Repetition
b. Dishonesty in a clinical setting
c. Moving roles when issues arose as opposed to addressing the issue.

Mitigating

a. Context and environment you were working in
b. Long career before the issues arose
c. Personal issues in your private life

Mr James submitted that the dishonesty is less serious as it was a one-off incident that was opportunistic with no financial gain. He further submitted that there has been no evidence to suggest that there has been repetition of the dishonesty.

Mr James submitted that the risk is too great for conditions of practice, therefore a suspension order is appropriate and proportionate in these circumstances.

At the outset of Mr Buxton's submissions, he stated that you were working at all three practices and you did not move when issues arose.

Mr Buxton submitted that you have made efforts to try and remediate by undertaking and completing additional training. He further submitted that you have demonstrated insight and an understanding into your actions and shown remorse. Mr Buxton stated that the concerns do not show that you have attitudinal concerns.

Mr Buxton submitted that you have been subject to an interim suspension order for over three years so you have been unable to maintain your nursing skills. He further submitted that the dishonesty falls at the lower end of the spectrum as it was a single incident, in relation to an asthma review.

Mr Buxton supported the NMC sanction bid of imposing a suspension order, it being an appropriate and proportionate sanction given the circumstances. He submitted that the panel should also take into consideration that you have already been subject to an interim suspension order for three years.

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 Sanctions Guidance (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:

- Pattern of lack of competence over a period of time.
- Repetitive instances of conduct which put patients at risk of harm.

- Dishonesty in a clinical setting

The panel also took into account the following mitigating features:

- Single, spontaneous and unplanned conduct in relation to the dishonesty matter
- You were working in a busy, pressurised environment with issues surrounding adequate support
- Your lengthy career
- Some early admissions
- Remorse and insight
- Health and significant personal issues

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict 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 actions were not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *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; and*
- *Conditions can be created that can be monitored and assessed.*

The panel was satisfied that your case fell within all of the above categories.

The panel therefore determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel inferred that you would be willing to comply with conditions of practice, as you have previously completed training and identified the skills you needed to work on, such as time management, assertiveness and record keeping.

The panel had regard to the fact that you have been subject to an interim suspension order for three years and wanted to put in place appropriate and proportionate conditions to facilitate your return to safe practice given your experience and long-standing career before the issues arose. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse. In regard to the finding of dishonesty, the panel accepted that this was at the lower end of the spectrum and that it was highly unlikely to be repeated.

Balancing all of these factors, the panel determined that 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 or a striking-off order would be disproportionate given the circumstances of your case.

Having regard to the matters it has identified, the panel has 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.

In making this decision, the panel carefully considered the submissions of Mr James in relation to the sanction that the NMC was seeking in this case. However, the panel considered that imposing a suspension order would be disproportionate and that a conditions of practice order strikes a fair balance between the overarching objective to protect the public and uphold the public interest and your own interests.

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 ensure that you are supervised at any time 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.

2. You must meet with your supervisor, who must be another registered nurse, once a week for the first month of this order and then at such frequency as your supervisor deems appropriate but not less than once a month thereafter to discuss your conduct and performance in the in the workplace with specific focus on record keeping, time management and communication skills.

3. You must send your case officer the reports from your supervisor no less than seven days prior to any review of this order which provide details of your performance and conduct in the workplace with specific focus on record keeping, time management and communication skills.

4. You must keep us 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.

5. You must keep us 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.

6. 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.

7. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.

b) Any investigation started against you.
c) Any disciplinary proceedings taken against you.

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 18 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. 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:

- Evidence of up-to-date testimonials from your current employer and/or colleagues
- Your attendance at any subsequent review
- Notes of the supervision meetings

Submissions on interim order

The panel took account of the submissions made by Mr James. He submitted that an interim conditions of practice order for 18 months is appropriate to cover the appeal period, on the grounds of public protection and public interest.

Decision and reasons on interim order

The panel 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 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.

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.