Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 28 November 2022 – 5 December 2022
Thursday 22 December 2022
Thursday 9 March 2023
Monday 11 September – Tuesday 12 September 2023

Virtual Hearing

Name of Registrant:	**Julie Alison Beck**
NMC PIN	05H2069E
Part(s) of the register:	RNMH: Registered Nurse – Mental Health (10 July 2006)
Relevant Location:	Worcestershire
Type of case:	Misconduct
Panel members:	Nicola Jackson (Chair, Lay member) Frances Clarke (Registrant member) Vicki Harris (Lay member)
Legal Assessor:	Christopher Mckay
Hearings Coordinator:	Sharmilla Nanan (28 November 2022 – 5 December 2022) and (22 December 2022) Taymika Brandy (9 March 2023) and (11 September –12 September 2023)
Nursing and Midwifery Council:	Represented by Joe O'Leary, Case Presenter (28 November 2022 – 5 December 2022) Represented by Helen Guest, Case Presenter (22 December 2022) Represented by Sally Denholm, Case Presenter (9 March 2023) and (11 September –12 September 2023
Ms Beck:	Present and unrepresented (28 November 2022 – 5 December 2022) and (22 December 2022) Not present and unpresented (9 March 2023) and (11 September –12 September 2023)

Facts proved by admission:	Charge 2b
Facts proved:	Charges 1c,1f, 1g and 2c
Facts not proved:	Charges 1a, 1b, 1d, 1e, 2a, 3, 4a, 4b and 4c
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (2 years)**
Interim order:	**Conditions of practice order (18 months)**

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

At the outset of the hearing, Mr O'Leary on behalf of the Nursing and Midwifery Council (NMC), made a request that parts of this case be held in private on the basis [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You indicated that you supported the application to the extent that any reference to [PRIVATE] should be heard in private.

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

The panel determined to go into private session in connection with any references to [PRIVATE] as and when such issues are raised in order to protect your right to privacy.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr O'Leary, to amend the stem of the charges and the wording of charges 1b, 1c, 1f, 2c and 4b.

The proposed amendments were to correct alleged facts, dates and typographical errors. It was submitted by Mr O'Leary that the proposed amendments would provide clarity and more accurately reflect the evidence.

Original wording of the stem of the charges and charges

"That you, a registered nurse, whilst engaged as an agency nurse working on the night shift of 24/25 December 2020 at Perrin House, Friends of the Elderly, Malvern;

1. *Failed to safely administer medication and patient care in that you:*

a) …

b) *Failed to carry out a ketone test for Patient A on the morning of 25 December 2020 despite her express request that you do so.*

c) *Failed to give Resident B their 0700 prescribed dose of lanzoprazole on 25 December 2020.*

d) …

e) …

f) *Administered co-beneldopa to Resident E at 2200 on 24 December 2020 which was a once daily medication that had already been given when prescribed as a morning dose*

2. *Failed to maintain accurate records relating to medication administration in that you:*

a) …

b) …

c) *Inaccurately signed Resident C's MAR chart indicating that you had administered the PRN paracetamol on 24 December 2020 when you had not done so.*

3. …

4. *Your actions were dishonest in that:*

a) …

b) *In respect of charge 2c, you knew when you signed Resident C's MAR chart to indicate that you had administered PRN paracetamol on 24 December 2020, that you had not done so.*

c) *…"*

Proposed changes to *the wording the stem of the charges and charges*

*"That you, a registered nurse, whilst engaged as an agency nurse working on the night shift of 24/25 December 2020 at Perrin**s** House, Friends of the Elderly, Malvern;*

1. *Failed to safely administer medication and patient care in that you:*

   a) *…*

   b) *Failed to carry out a ketone test for ~~Patient~~ **Resident** A on the morning of 25 December 2020 despite her express request that you do so.*

   c) *Failed to give Resident B their 0700 prescribed dose of ~~lanzoprazole~~ **lansoprazole** on 25 December 2020.*

   d) *…*

   e) *…*

   f) *Administered co-beneldopa to Resident E at 2200 on 24 December 2020 which was a once daily medication ~~that had already been given~~ ~~when prescribed as a morning dose~~. **which was prescribed to be given in the morning.***

2. *Failed to maintain accurate records relating to medication administration in that you:*

a) …

b) …

*c) Inaccurately signed Resident C's MAR chart indicating that you had administered the PRN paracetamol on ~~24~~ **25** December 2020 when you had not done so.*

3. …

4. Your actions were dishonest in that:

a) …

*b) In respect of charge 2c, you knew when you signed Resident C's MAR chart to indicate that you had administered PRN paracetamol on ~~24~~ **25** December 2020, that you had not done so.*

c) …"

You stated that you did not have any comments on the proposed amendments and thought that it was fine to make the suggested amendments to the charges.
The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such amendments, as applied for, were 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 amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit Resident A's hearsay evidence

The panel heard an application made by Mr O'Leary under Rule 31 to allow the hearsay evidence of Resident A, exhibited by Witness 2, into evidence. He referred to the signed witness statement of Witness 2, dated 8 October 2021, who stated that *"Resident A has since passed away"* and submitted in these circumstances it would be impossible for Resident A to attend the hearing. He referred the panel to a number of relevant judgments and submitted that it is a matter of fairness to admit Resident A's hearsay evidence. He submitted that the panel could attach the appropriate weight, if any, to Resident A's hearsay evidence if it is admitted into evidence.

You stated that you did not do the things that Resident A alleged. You stated that it was your word against Resident A's and that you would not be able to question her.

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 Resident A's hearsay evidence serious consideration. The panel considered the fairness to both you and the NMC.

The panel took into consideration that you would not be able to cross examine Resident A on her account.

The panel noted that Resident A's evidence was a contemporaneous record of her statements after your shift at the Home and that it was checked with her at the time. The panel bore in mind that it would hear evidence from Witness 1 who spoke with Resident A following your shift at the Home and Witness 3 who took Resident A's statement. It noted that Resident A's evidence was crucial to charges 1a and 1b, as you and Resident A were the only ones present at the material time. The panel bore in mind that if it did not admit the Resident A's evidence it was likely that the related charges would fall away. The panel had no information that Resident A had any reason to fabricate her account. The panel took into account that it had a responsibility to uncover what happened at the material time.

In these circumstances, the panel came to the view that the evidence of Resident A was relevant and that it would be fair to accept it. The panel would give the evidence the appropriate weight once it had evaluated it.

Details of charges

That you, a registered nurse, whilst engaged as an agency nurse working on the night shift of 24/25 December 2020 at Perrins House, Friends of the Elderly, Malvern;

1. Failed to safely administer medication and patient care in that you:

    a) Failed to give Resident A their prescribed 2200 hour dose of hydroxyzine on 24 December 2020. **[NOT PROVED]**

    b) Failed to carry out a ketone test for Resident A on the morning of 25 December 2020 despite her express request that you do so. **[NOT PROVED]**
    c) Failed to give Resident B their 0700 prescribed dose of lansoprazole on 25 December 2020. **[PROVED]**

    d) Administered a dose of cyclizine in excess of that prescribed at 2200 on 24 December to Resident D. **[NOT PROVED]**

    e) Failed to give Resident D their prescribed 2200 hour dose of nefopam on 24 December 2020. **[NOT PROVED]**

    f) Administered co-beneldopa to Resident E at 2200 on 24 December 2020 which was a once daily medication which was prescribed to be given in the morning. **[PROVED]**

    g) Failed to give Resident E their prescribed 2200 dose of co-careldopa on 24 December 2020. **[PROVED]**

2. Failed to maintain accurate records relating to medication administration in that you:

    a) Inaccurately signed Resident A's MAR chart indicating that you had administered the prescribed hydroxyzine medication at 2200 on 24 December 2020 when you had not done so. **[NOT PROVED]**

    b) Failed to sign the MAR chart for Resident F for medication administered at 0700 on 25 December 2020. **[PROVED BY ADMISSION]**

    c) Inaccurately signed Resident C's MAR chart indicating that you had administered the PRN paracetamol on 25 December 2020 when you had not done so. **[PROVED]**

3. On 25 December 2020, inaccurately told Resident A that you had administered her hydroxyzine medication whilst she was sleeping or said words to that effect. **[NOT PROVED]**

4. Your actions were dishonest in that:

    a) In respect of charge 2a, you knew when you signed Resident A's MAR chart to indicate that you had administered the prescribed hydroxyzine medication at 2200 on 24 December 2020, that you had not done so; **[NOT PROVED]**

    b) In respect of charge 2c, you knew when you signed Resident C's MAR chart to indicate that you had administered PRN paracetamol on 25 December 2020, that you had not done so. **[NOT PROVED]**

    c) In respect of charge 3, you knew when you told Resident A that you had administered her hydroxyzine medication whilst she was sleeping or said words to that effect, that you had not done so. **[NOT PROVED]**

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

Admissions to the charges

At the outset of the hearing, you informed the panel that you made full admissions to charge 2b.

The panel therefore finds charge 2b proved in its entirety, by way of your admissions. It was agreed that whilst some qualified admissions had been made to some of the remaining charges, these were not formal admissions, and all of the remaining charges remain not admitted.

Background

The charges arose whilst you were employed as an agency registered nurse by Newcross Healthcare Solutions (the Agency). You were allocated a shift at Perrins House (the Home), a site of the Friends of the Elderly care homes, for the night shift commencing 24 December 2020 until the morning of 25 December 2020. You had not worked at the Home before these incidents.

Prior to the allegations you had worked with the Agency previously before leaving and returning on 8 October 2020. You actively worked with clients of the agency from the 28 November 2020 and completed three shifts with the Agency before working at the Home.

You qualified as a registered nurse in 2005 since when there had been no previous regulatory concerns.

At the material time, the Home had 31 spaces for residents with 23 residents in occupancy at the Home.

On the morning of 25 December 2020, Witness 1 attended the Home to give her Christmas wishes to the staff and residents and on arrival she was informed of a *'number of problems with the medications'* on the previous shift as detailed in the charges.

Witness 1 reported the issues to the Agency on 29 December 2020 and she sent a further email on 30 December 2020. You were asked to return to the Home to sign missing entries from the MAR charts. Relevant referrals were also made to local safeguarding and the CQC (Care Quality Commission). You participated in the Agency's local investigation by writing a statement, as requested, and attended an investigation meeting on 31 December 2020.

Subsequently, it is alleged that you were dishonest, when you failed to administer medication to two residents, and yet you had signed the resident's respective MAR charts to indicate that you had administered it. It is also alleged that you were dishonest when you told the resident that you had administered her medication whilst she was sleeping or words to that effect, when you had not done so.

Decision and reasons on facts

In reaching its decisions on the remaining disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr O'Leary on behalf of the NMC and by you.

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

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

- Witness 1: Registered Manager of the Home and is a registered nurse.

- Witness 2: Previously employed as Business Centre Manager at the Agency who conducted the investigation into the incidents which took place at the home. She had not met you prior to this incident.

- Witness 3: A registered nurse who works at the Home who met you for the first time at handover on Christmas day.

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor including reference to the judgment in *Ivey v Genting Casinos* [2017] UK SC 67S. It explained that there was a two-stage test to be applied firstly, to consider what the registrant's genuine state of mind at the time was and secondly, to consider in light of that state of mind were her actions dishonest according to the standards of ordinary decent people.

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

Charge 1a

> "That you, a registered nurse, whilst engaged as an agency nurse working on the night shift of 24/25 December 2020 at Perrins House, Friends of the Elderly, Malvern;
>
> 1. Failed to safely administer medication and patient care in that you:

a) Failed to give Resident A their prescribed 2200 hour dose of hydroxyzine on 24 December 2020."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 3 and your oral evidence.

The panel had regard to Resident A's MAR chart dated from 30 November 2020 to 27 December 2020. It noted that on the front of the MAR chart you had signed the 22.00 entry of Hyroxyzine 10 mg tablet. The panel also noted that there were entries on the back of the MAR chart made by you. The first entry stated, *"Hyroxyzine 10 mg tablet not available"* which was crossed out and another entry stated, *"Error – medication given as prescribed".* Next to these entries was a time of '*21.00hrs'* which was crossed out and underneath was written *'21.10hrs'.*

The panel took into consideration your oral evidence and that you admitted that the timings recorded on the back page of the MAR chart did not seem right. It noted you had stated that you had provided the dose to Resident A around midnight or the early hours of morning as you could not initially find the drug to administer. The panel found your oral evidence credible as you had provided a detailed description of waking up Resident A to administer the hydroxyzine to her and vividly described Resident A putting her fingers in the medicines pot as she was blind to feel for the tablet before taking it with water. The panel found your account broadly consistent with your earlier accounts and the information recorded on the MAR chart. It noted that you accepted when you could not remember something about the evening in question and at the time, you had been feeling tired having recently [PRIVATE].

The panel considered the evidence of Witness 3 who had not worked nightshifts and was not familiar with Resident A at night.

The panel considered Resident A's contemporaneous hearsay account. It bore in mind that Resident A said that it was unusual for her not to remember her medication being administered to her. It noted that Resident A was described as dogmatic in respect of taking her medication and her care in general. It also took into consideration the evidence of Witness 1 and Witness 3 who said in their oral evidence, that Resident A believed that she was always right but that this was not always the case. The panel bore in mind that it did not have the opportunity to ask questions of Resident A, nor had she been cross examined by you.

The panel considered Witness 1's oral evidence that Resident A could *'take against people'* she did not like, and the panel noted that you said Resident A became unsettled after you simply commented to Resident A that it was your first time completing a ketone test.

The panel determined that it preferred the account you provided in oral evidence and decided to attach less weight to the hearsay evidence of Resident A.

The panel considered that Resident A probably forgot about the administration of the hydroxyzine dose in the middle of the night and accordingly decided on the balance of probabilities to find this charge not proved.

Charge 1b

> "That you, a registered nurse, whilst engaged as an agency nurse working on the night shift of 24/25 December 2020 at Perrins House, Friends of the Elderly, Malvern;
>
> 1. Failed to safely administer medication and patient care in that you:
>
> b) Failed to carry out a ketone test for Resident A on the morning of 25 December 2020 despite her express request that you do so."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the hearsay evidence of Resident A and your oral evidence. The panel bore in mind that there was no ketone test recorded for this date in the resident's timeline and that it did not have access to the diabetic monitoring form on which any such test should have been recorded.

The panel considered the hearsay evidence of Resident A who said in her contemporaneous statement to Witness 3 that you were 'unable to complete' a ketone test as you did not know how to do the test.

The panel considered that you said in your oral evidence that there was no alarm triggered to say that there was a need for a ketone test but that Resident A had requested that you complete one. The panel considered your oral evidence that you did a ketone test for Resident A and that you had simply commented to Resident A that you had never done a ketone test before. You noted that this may have worried her as she became upset and angry with you. You stated you had been unable to document the test as the resident became angry and told you to leave her room.

The panel bore in mind that this was your first attempt to do a ketone test, on your first time in the home on Christmas eve. The panel determined that there was no cogent evidence that you had not done the test and found this charge not proved on the balance of probabilities.

Charge 1c

> "That you, a registered nurse, whilst engaged as an agency nurse working on the night shift of 24/25 December 2020 at Perrins House, Friends of the Elderly, Malvern;
>
> 1. Failed to safely administer medication and patient care in that you:
>
> c) Failed to give Resident B their 0700 prescribed dose of lansoprazole on 25 December 2020."

This charge is found PROVED.

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

The panel considered the MAR chart dated, from 30 November 2020 to 27 December 2020. It noted that there was a mark in the box for the lansoprazole on the date of 25 December 2020. The panel bore in mind the oral evidence of Witness 1 who stated that the nurse administering medication on 26 December 2020 to Resident B started to record her administration of medication in this box but then crossed it out and added her signature on the correct date. She also stated that there were two doses left when there should have only been one on the 26 December 2020. The panel considered Witness 1's evidence in this regard to be credible and reliable.

The panel noted you said in evidence, *"you didn't knowingly not give it, but it is likely you did not give it".*

The panel considered the evidence before it and found this charge proved on the balance of probabilities.

Charge 1d

> "That you, a registered nurse, whilst engaged as an agency nurse working on the night shift of 24/25 December 2020 at Perrins House, Friends of the Elderly, Malvern;
>
> 1. Failed to safely administer medication and patient care in that you:
>
> d) Administered a dose of cyclizine in excess of that prescribed at 2200 on 24 December to Resident D."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account evidence of Witness 1, the documentary evidence of Witness 2 and your oral evidence.

The panel took into consideration Witness 1's evidence that nurses were meant to count any tablets not in blister packs prior to administering medication.

The panel referred to the MAR chart dated 30 November 2020 to 27 December 2020. It noted at 10pm on 24 December 2020 you recorded on the MAR chart that there were 21 tablets remaining and it appeared as though three tablets had been administered from the last count of 24 tablets at 14.00hrs on 24 December 2020. It bore in mind that there was no count or signature at the 7am entry on 25 December 2020. However, it noted that Witness 1 had counted 22 tablets during her count on 25 December 2020.

The panel noted the administrative errors on the MAR chart and took into consideration the evidence it heard that you had not signed the MAR charts for some of the other residents in the Home.

In the interview with Witness 2, on 31 December 2020, the interview notes document:

> *"[Witness 2] Asked Julie to discuss further the alleged allegation stated on the email regarding 100mg of cyclizine being administered instead of the 50mg prescribed?*
> *[Julie Beck] Stated she would not have given the resident two tablets she only administered 1 unless the 1 tablet was a dose of 100mg and not 50mg then she may have made the error this way.*
> *…*
> *[Witness 2] advised that one of the alleged allegations – administering 100mg cyclizine and not 50mg this has had to go to safeguarding.*
> *[Julie Beck] Said she did not do this..*
> *[Witness 2] stated Julie had mentioned she may have administered he incorrect amount if the dose was larger in in the tablet."*

The panel was of the view that the count accorded with a dose having been provided to Resident D at 10pm on 24 December 2020 and a dose being provided at 7am on 25 December 2020. It was the panel's view that you had written the pill count incorrectly at 22.00hrs it was therefore not satisfied that the alleged overdose had taken place nor had the NMC had adequately discharged its burden of proof in respect of this charge. The panel therefore found this charge not proved on the balance of probabilities.

Charge 1e

> "That you, a registered nurse, whilst engaged as an agency nurse working on the night shift of 24/25 December 2020 at Perrins House, Friends of the Elderly, Malvern;
>
> 1. Failed to safely administer medication and patient care in that you:
>
> e) Failed to give Resident D their prescribed 2200 hour dose of nefopam on 24 December 2020."

This charge is found NOT PROVED.

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

The panel considered the evidence of Witness 1 that a loose tablet had been found in the nefopam box which had not been administered to Resident D during your shift.

The panel referred to Resident D's MAR chart dated 30 November 2020 to 27 December 2020 and your oral evidence that you had signed that you had administered nefopam to Resident D on 24 December 2020. It noted that you said in your evidence that you would not leave a loose tablet in a medication box as it would be contaminated. The panel noted your focus on care, safety, ethics and honesty.

The panel was of the view that Witness 1 had speculated that the loose tablet found in the nefopam box was a consequence from the shift you worked but did not provide any cogent information as to why. In the circumstances, the panel find this charge not proved on the balance of probabilities.

Charges 1f and 1g

> "That you, a registered nurse, whilst engaged as an agency nurse working on the night shift of 24/25 December 2020 at Perrins House, Friends of the Elderly, Malvern;
>
> 1. Failed to safely administer medication and patient care in that you:
>
> f) Administered co-beneldopa to Resident E at 2200 on 24 December 2020 which was a once daily medication which was prescribed to be given in the morning.
> g) Failed to give Resident E their prescribed 2200 dose of co-careldopa on 24 December 2020."

These charges are found PROVED.

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

The panel referred to Resident D's MAR chart dated 30 November 2020 to 27 December 2020.

The panel considered the evidence of Witness 1 that on the morning of 25 December 2020, there was one less dose of co-beneldopa than there should have been which suggested that the wrong drug was given. It noted in Witness 1's statement she stated:

"On checking the amounts of these medications, I noted that the co-careldopa has been signed as administered on 24 December 2020 at 22:00, but the amount in the blister pack had not gone down for that day and that the co-beneldopa which although marked as 'A' for refused at 7am on 25 December, was if fact one down, that it should have been (from the MAR chart reading). I marked the updated and correct tally on that section of the chart as '24'"

It noted that Witness 1 had counted the doses the next morning and that she took care during her count and found an extra dose of co-careldopa and one less dose of co-beneldopa. The panel considered Witness 1 to be a reliable and credible witness in respect of this charge.

The panel noted that in your oral evidence that you said it was possible that you mixed the two drugs up.

The panel was of the view that it was more likely than not, that you mixed up the two medications co-careldopa and co-beneldopa, administered a dose of co-beneldopa and failed to administer the prescribed dose of co-careldopa at 2200 on 24 December 2020 to Resident E. The panel therefore found charges 1f and 1g proved on the balance of probabilities.

Charge 2a

"2. Failed to maintain accurate records relating to medication administration in that you:

a. Inaccurately signed Resident A's MAR chart indicating that you had administered the prescribed hydroxyzine medication at 2200 on 24 December 2020 when you had not done so."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence and findings outlined in charge 1a.

The panel had regard to Resident A's MAR chart dated from 30 November 2020 to 27 December 2020 which you had signed to indicate you had administered hydroxyzine at 2200 on 24 December 2020.

The panel had regard to your oral evidence in which you said that you had given this medication to Resident A after midnight or in the early hours of the 25 December 2020. It noted that you had spoken about this at handover.

The panel bore in mind that this medication was not administered at exactly the specific time of the prescription, but it was satisfied that it had been administered within a reasonable time period by you to the resident. The panel therefore found this charge not proved on the balance of probabilities.

Charge 2c

> "2. Failed to maintain accurate records relating to medication administration in that you:
>
> c. Inaccurately signed Resident C's MAR chart indicating that you had administered the PRN paracetamol on 25 December 2020 when you had not done so."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1 and the documentary evidence of Witness 2.

The panel took into consideration Witness 1's evidence that nurses were meant to count tablets or capsules prior to administering medication.

The panel had regard to Resident C's MAR chart dated from 30 November 2020 to 27 December 2020. It noted that there was a recording of 66 tablets at 14.00hrs on 24 December 2020. The next count was 64 at 07.00hrs on 26 December 2020 despite your signature indicating that you have given them at 07.00hrs on the 25 December 2020. You stated in cross examination that the 'N' marked at 22.00hrs on the 24 December 2020, was your entry. You were not sure if you gave the paracetamol on 25 December 2020, although you admitted that it was possible or even probable that you had not. You stated that you would have signed the MAR chart thinking that you had given it, but you had no recollection of dissolving the tablets and you may have signed the MAR chart incorrectly.

The panel considered the evidence of Witness 1 who said that the count of the PRN paracetamol on 25 December 2020 was 64 and stated that she thought that the markings on the MAR chart were your signature.

The panel was satisfied that there was adequate information to demonstrate that the PRN paracetamol had not been administered to Resident C by you and therefore found the charge proved.

Charge 3

> "3. On 25 December 2020, inaccurately told Resident A that you had administered her hydroxyzine medication whilst she was sleeping or said words to that effect."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account its earlier finding that you did administer Resident A's hydroxyzine medication in charge 1a, having woken her from her sleep in order to administer the medication. The panel therefore found this charge not proved on the balance of probabilities.

Charge 4a

"4. Your actions were dishonest in that:

a) In respect of charge 2a, you knew when you signed Resident A's MAR chart to indicate that you had administered the prescribed hydroxyzine medication at 2200 on 24 December 2020, that you had not done so"

This charge is found NOT PROVED.

In reaching this decision, the panel took into account that it found charge 2a not proved and concluded that the MAR chart record was true and therefore there was no dishonesty in signing the record. Consequently, the panel determined that charge 4a is not proved.

Charge 4b

"4. Your actions were dishonest in that:

b) In respect of charge 2c, you knew when you signed Resident C's MAR chart to indicate that you had administered PRN paracetamol on 25 December 2020, that you had not done so."

This charge is found NOT PROVED.

The panel had found charge 2c proved. In considering this charge, it took into account your evidence that you had not knowingly signed the MAR chart incorrectly. It also took into account your evidence that you were [PRIVATE]. In addition, the panel noted your good character and the absence of any previous regulatory findings against you. The panel concluded that you had made an honest mistake and that ordinary decent people would not consider that you had been dishonest. Consequently, the panel determined that charge 4c is not proved.

Charge 4c

"4. Your actions were dishonest in that:

c) In respect of charge 3, you knew when you told Resident A that you had administered her hydroxyzine medication whilst she was sleeping or said words to that effect, that you had not done so."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account that it found charge 3 not proved and therefore there was no dishonesty in telling Resident A that you had administered her hydroxyzine medication while she was in fact awake. Consequently, the panel determined that charge 4c is not proved.

Decision and reasons on service of Notice of Hearing (Heard on 9 March 2023)

The panel was informed at the start of this hearing that Ms Beck was not in attendance and that the Notice of Hearing letter for the resuming hearing had been sent to Ms Beck's
registered email address by secure email on 19 December 2022.

Ms Denholm, on behalf of the NMC, submitted that it had complied with the requirements of Rule 32 (3) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the time, date and link to the hearing and, amongst other things, information about Ms Beck's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.
In the light of all of the information available, the panel was satisfied that Ms Beck has been served with the Notice of Hearing in accordance with the requirements of Rule 32 (2).

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

Before addressing the panel on proceeding in the absence of Ms Beck, Ms Denholm, on behalf of the NMC, made a request that this case be held in private, as [PRIVATE].

The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Having heard that there will be reference made to [PRIVATE], the panel determined to go into private only as and when such issues are raised in order to protect her right to privacy.

Decision and reasons on proceeding in the absence of Ms Beck

The panel next considered whether it should proceed in the absence of Ms Beck. It had regard to Rule 21 and heard the submissions of Ms Denholm who invited the panel to continue in the absence of Ms Beck.

Ms Denholm referred the panel to an email sent by Ms Beck on 8 March 2023, in response to an email from the NMC hearings coordinator providing the joining details and asking her to confirm her attendance. In the email Ms Beck states:

' [PRIVATE]

Please give my apologies to the panel and express my wish for the hearing to go ahead in my absence.'

Ms Denholm submitted that Ms Beck has acknowledged the Notice of Hearing and has expressed her wish for the hearing to proceed in her absence. She submitted that Ms Beck has not made an application for an adjournment.

Ms Denholm invited the panel to consider fairness to all parties and the public interest in the expeditious disposal of this case.

Ms Denholm referred the panel to the relevant cases of *R* v *Jones* [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162. She invited the panel to proceed in the absence of Ms Beck.

The panel accepted the advice of the legal assessor who referred to the cases of *Jones* and *Adeogba*.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *Jones.*

The panel has decided to proceed in the absence of Ms Beck. In reaching this decision, the panel has considered the submissions of Ms Denholm, Ms Beck's correspondence with the NMC and the advice of the legal assessor.

The panel had regard to the email sent by Ms Beck on 8 March 2023, received by the Hearings Coordinator and noted that in this email Ms Beck had expressed her '*wish*' for the hearing to proceed in her absence. The panel also considered that Ms Beck had previously engaged throughout these proceedings, in that she had attended the previous sitting of this substantive hearing and had given evidence in regard to the facts of this case. The panel noted that, as detailed in the email correspondence from Ms Beck, she is [PRIVATE]. The panel was of the view that it was not reasonable for Ms Beck to foresee these circumstances and therefore, it did not expect Ms Beck to have prepared documentation to put before the panel in respect of the next stages of this hearing, namely, misconduct and impairment.

The panel weighed up all of these considerations and concluded that although it was finely balanced, it was in the interest of all parties to see this case completed and that it would be fair and just, in light of Ms Beck's email, to proceed to the next stage of deciding on misconduct. At the misconduct stage the panel will take into account the evidence before it, including Ms Beck's evidence given previously. The panel considered that if it does find misconduct in this case, it would be in Ms Beck's interest to give evidence and/or provide the panel with information relating to the impairment stage. The panel also noted that before this case adjourned previously, the legal assessor in the presence of the NMC Case Presenter had explained to Ms Beck what information would be helpful to the panel's consideration at that stage.

In all the circumstances, the panel determined that it would proceed to consider the issue of misconduct and if it did move on to consider the issue of impairment, having regard to the principle of fairness, it would adjourn this hearing of its own volition, to allow Ms Beck reasonable time to submit evidence in relation to that stage.

Fitness to practise

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Ms Beck's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Denholm invited the panel to take the view that the facts found proved amount to misconduct and were in breach of The Code: Professional standards of practice and behaviour for nurses and midwives (2018) ("the Code"). She then directed the panel to specific paragraphs and standards and identified where, in the NMC's view, Ms Beck's actions amounted to a breach of the Code.

Ms Denholm submitted that Ms Beck's failures in the charges found proved related to medication errors, record keeping and medication administration. She referred the panel to the cases of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 and of *Nandi v GMC* [2004] EWHC 2317 (Admin) and invited the panel to consider the Code in its entirety.

Ms Denholm submitted that the concerns in this case relate to Ms Beck's clinical practice and ability to administer medication safely and accurately make a record of this. She submitted that these are fundamental and basic nursing skills that are at the heart of safe nursing practice. She submitted that these clear failings were serious misconduct and fall seriously short of the expected conduct of a registered nurse.

The panel accepted the advice of the legal assessor which included reference to the cases of *Rylands V GMC [1999]* Lloyds Rep Med 139 and *Nandi*.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Rylands* which defines misconduct as a *'a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious. The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct that would be regarded as deplorable by fellow practitioners.*

It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree'.

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

The panel, in reaching its decision, had regard to the protection of the public and the wider public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that Ms Beck's actions amounted to a breach of the Code. The panel considered that the following sections of the Code had been breached in this case:

'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*:*

[…]

10.3 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'

The panel initially considered whether Ms Beck's actions in each of the individual charges did fall short of the conduct and standards expected of a registered nurse. It determined specifically that, Ms Beck's actions in charges 2b and 2c breached section

10.3 of the Code and charges 1c,1f and 1g breached the stem of section 18 of the Code. While they all breached sections of the Code, the panel judged that not all the proven charges constituted by themselves professional misconduct.

However, the panel considered that the charges taken collectively did amount to serious clinical errors and failures, albeit, in respect of one medication round. The panel found in respect of Charge 1f and 1g, that these medications were for a resident suffering from Parkinson's and that it is important for these medications to be given according to their prescriptions at their respective times. The panel noted that although there was no evidence of actual patient harm, it was of the view that Ms Beck's actions were unacceptable and unsatisfactory.

The panel took into account the context of Ms Beck's working environment at the time, notably, that it was Christmas eve and that it had been her first time working in the Home. However, the panel considered that medications management is a basic and fundamental requirement of nursing practice and that Ms Beck's failure to administer medication correctly and accurately record administration of medication is poor nursing practice that falls far below the standards expected of a registered nurse.

The panel was of the view that Ms Beck's actions in the charges found proved were serious and fell far below the professional standards expected of a registered nurse and would be regarded as unacceptable by her colleagues and members of the public. The panel therefore determined that Ms Beck's actions were sufficiently serious to amount to misconduct.

The panel noted that in your meeting, after the conclusion of the previous stage with the Legal Assessor in the presence of the Case Presenter, he explained to you what information the panel would find helpful for you to provide in advance of the next stages of the hearing.

The panel confirm that it would still find it helpful if you can send to the NMC in advance of the next session the following:

- Testimonials from work colleagues and/or any personal character references.
- Evidence of your attendance at virtual or in-person courses on medication administration, record keeping and any other CPD.
- References from any employers since the events in question whether or not involved in healthcare.
- [PRIVATE] at the time of the matters concerning this hearing.
- A structured reflective piece from you using e.g. the NMC template. This should include your reflection on why the misconduct occurred, what you would do differently in the future and how your behaviour may have affected patients, work colleagues and the reputation of the nursing profession.

This will be confirmed to Ms Beck in writing.

Decision and reasons on application for hearing to be held in private (Heard on 11 September 2023)

At the outset of the hearing, the panel invited Ms Denholm, on behalf of the NMC, to make an application for the entirety of the resuming hearing to held in private.

Ms Denholm requested in her application that this hearing be held wholly in private as there will be reference to Ms Beck's health.

The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Having heard [PRIVATE], the panel determined that this hearing be held wholly in private in order to protect Ms Beck's right to privacy.

Decision and reasons on service of Notice of Hearing (Heard on 11 September 2023)

The panel was informed at the start of this hearing that Ms Beck was not in attendance and that the Notice of Hearing letter for the resuming hearing had been sent to Ms Beck's last known address by recorded and by first class post on 1 August 2023. This address was provided Ms Beck to the NMC in an email dated 25 May 2022.

Ms Denholm, on behalf of the NMC, submitted that it had complied with the requirements of Rule 32 (3) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the time, dates and link to the resuming hearing and, amongst other things, information about Ms Beck's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Beck has been served with the Notice of Hearing in accordance with the requirements of Rule 32 (2).

Decision and reasons on proceeding in the absence of Ms Beck

The panel next considered whether it should proceed in the absence of Ms Beck. It had regard to Rule 21 and heard the submissions of Ms Denholm who invited the panel to continue in the absence of Ms Beck.

Ms Denholm referred the panel to a note of a telephone conversation between Ms Beck and her NMC case officer dated 3 July 2023. The note states that:

'[…]. [PRIVATE] *The registrant said that going back to nursing was the last thing on her mind. […] I told the registrant that she has an IO hearing tomorrow and that I assume she wouldn't be attending. The registrant said she would not be attending. […] I asked if this applied to the substantive hearing also. The registrant said yes it did'*

Ms Denholm referred to the relevant cases of *Jones* and *Tait v Royal College of Veterinary Surgeons* [2003] UKPC 34. She submitted that Ms Beck has confirmed that she would not be attending this resuming hearing, she has made no application for an adjournment and there is no reason to suppose that adjourning would secure her attendance at some future date.

Ms Denholm submitted that the panel had previously adjourned this hearing to afford Ms Beck time to re-engage with these proceedings, however Ms Beck's position is unchanged in that she remains unwell. For these reasons, Ms Denholm invited the panel to exercise its discretionary power and to proceed in the absence of Ms Beck.

The panel accepted the advice of the legal assessor which included reference to Rule 32 of the Rules and the relevant cases of *Jones* and the *Adeogba*.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *Jones.*

The panel has decided to proceed in the absence of Ms Beck. In reaching this decision, the panel has considered the submissions of Ms Denholm, Ms Beck's correspondence with the NMC and the advice of the legal assessor. It has had regard to the factors set out in the decision of *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Ms Beck has engaged with the NMC and confirmed in a telephone conversation with her NMC case officer that she '*was fine for the hearing to continue without her'*;

- No application for an adjournment has been made by Ms Beck;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- This case has previously adjourned on two occasions and it is in the interest of Ms Beck and the NMC that this case proceeds without further delay; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Beck.

Submissions on impairment

Ms Denholm addressed the panel on the issue of impairment and 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.

Ms Denholm reminded the panel that the issue of impairment is a forward-looking exercise and referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin). She submitted that limbs a), b) and c) of Dame Janet Smith's test as set out in the Fifth Report from Shipman were engaged by Ms Beck's past actions.

Ms Denholm submitted that Ms Beck in the past acted and/or is liable in the future to act so as to put patients at unwarranted risk of harm and did so as a result of her medication administration errors. She submitted that there is a real risk that such conduct could be repeated as Ms Beck has not practised since the incidents and therefore, has not evidenced a period of safe and effective practice.

Ms Denholm submitted that Ms Beck in the past brought and/or is liable in the future to bring the medical profession into disrepute. She submitted that patients should be confident in a nurse's ability to safely administer medication and maintain accurate

records. She submitted that these are basic and fundamental nursing duties that Ms Beck failed to carry out.

Ms Denholm further submitted that Ms Beck has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession. She submitted that medication administration and record keeping are fundamental tenets of the profession and Ms Beck's actions constituted a breach of these fundamental tenets.

Referring to the case *Cohen v GMC* [2008] EWHC 581 (Admin), Ms Denholm invited the panel to consider current and future risk, whether the concerns identified were capable of remediation, whether they have been remedied and whether there was a risk of repetition at some point in the future. She submitted that whilst Ms Beck's misconduct is capable of remediation through relevant training and supervision, the concerns have not been remediated.

Ms Denholm submitted that Ms Beck has expressed that she has no intention to return to nursing practice in the near future and that she has not practised since these NMC proceedings commenced. Ms Denholm submitted that Ms Beck has very limited insight and referred the panel to Ms Beck's email to the NMC dated 6 July 2021 which states:

> '[PRIVATE]'

In light of this email, Ms Denholm invited the panel to consider Ms Beck's level of insight as she has not provided any further information. Ms Denholm reminded the panel of its overarching objectives to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest.

For these reasons, Ms Denholm invited the panel to make a finding of current impairment on public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to the case of *Cohen* and to the NMC guidance titled 'Insight and strengthened practice' reference: FTP-13.

Decision and reasons on impairment

The panel next went on to decide if, as a result of this misconduct, Ms Beck's fitness to practise is currently impaired.

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

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

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

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

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

profession into disrepute; and/or

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

d)…'

The panel determined that limbs a), b) and c) are engaged in this case.

The panel finds that Ms Beck's failure to administer medication correctly and accurately record administration of medication placed patients at unwarranted risk of harm. The panel has determined that Ms Beck's misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute by her past actions.

The panel recognised that it had to make a current assessment of Ms Beck's fitness to practice, which involved not only taking account of past misconduct but also what has happened since the misconduct came to light. The panel had regard to the case of *Cohen* and considered whether the concerns identified were capable of remediation, whether they have been remedied and whether there was a risk of repetition at some point in the future. The panel determined that the misconduct is such that it can be remediated through relevant training, insight and evidence of strengthened practice.

The panel then went on to consider whether Ms Beck remained liable to act in a way likely to put patients at risk of harm, to bring the profession into disrepute and to breach fundamental tenets of the profession in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and whether there was any evidence of insight and strengthened practice.

Regarding insight, the panel first took into account Ms Beck's email dated 6 July 2021, in which she states:

‘ [PRIVATE]

[….]

I did start to count the medications but there were several discrepancies that I stopped [sic] in order to save time as I was working at a slower pace than usual. There were also gaps on the charts from previous administrations. I did leave gaps on the charts and this can be a high risk error if it Is [sic] viewed as the resident has not had the medication and is then given the medication again causing overdose and potential harm. Unfortunately, leaving gaps in the medication charts is one of the most common in most nursing homes and nurses generally will question reason for gaps in documentation. I did know [sic] realise how unwell I was even though I no longer had the virus. The previous shifts I worked before Having [sic] [PRIVATE].

[PRIVATE].*’*

The panel accepted that in this email, Ms Beck acknowledges [PRIVATE].

[PRIVATE].

In her email dated 6 July 2021, Ms Beck also states:

‘I take pride in my role as a competent nurse and deeply regret that I made the unfortunate decision to go into work on 24/12/2020. I love and miss my role providing safety, compassion and best quality of care, trying meet the diverse needs of the individual people in my care, with honesty and integrity’

The panel noted that no concerns had been raised prior to this incident. However, the panel was of the view that in this email, Ms Beck had not fully reflected on what she would do differently, the totality of her actions and the impact of her actions on patients, colleagues, the reputation of the profession and the public confidence. Consequently the panel concluded that Ms Beck’s insight is limited.

The panel then considered what steps Ms Beck has taken to strengthen her practice and to remediate the concerns. The panel bore in mind that [PRIVATE]. However, in the absence of any evidence about steps to strengthen her practice such as evidence of relevant training or a period of safe and effective practice, the panel concluded that Ms Beck had not remediated her misconduct. In all the circumstances, the panel considered that there is a risk of repetition and that should Ms Beck return to practice, she remained liable to act in a way which could place patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objective of the NMC is: to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel concluded, given the nature of Ms Beck's misconduct, that public confidence in the profession and in the regulator would be undermined if a finding of impairment were not made in this case. Therefore, the panel also finds Ms Beck's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Beck's fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

The panel considered this case very carefully and decided to make a conditions of practice order for a period of 2 years. The effect of this order is that Ms Beck's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Denholm submitted that the appropriate and proportionate sanction in this case is a conditions of practice order for a period of 12 months. Ms Denholm referred to the SG and reminded the panel to consider the principle of proportionality, in that it must find a fair balance between Ms Beck's rights and the overarching objective of public protection. She also stated that any sanction imposed must be proportionate and go no further than is necessary in order to protect the public and uphold the public interest. Mrs Denholm then outlined aggravating and mitigating features for the panel to consider.

Ms Denholm invited the panel to consider the sanctions in ascending order, and to have regard to the public protection and public interest issues in deciding on the most appropriate and proportionate sanction. She submitted that taking no action would not address the public protection and public interest issues in this case. She submitted that a caution order is only appropriate where the registrant is fit to practise without restriction and in this case, a caution order would not be appropriate as it would not provide sufficient safeguard against the current risks identified.

In addressing a conditions of practice order, Ms Denholm referred to the SG and explained that a conditions of practice order may be appropriate as the following factors are apparent:

- *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;*

Ms Denholm submitted that whilst Ms Beck has confirmed she has no intention to return to nursing currently, she may wish to return in the future. Ms Denholm reminded the panel that any conditions imposed must be relevant, proportionate, measurable and workable. She submitted that Ms Beck has cooperated with the NMC until [PRIVATE] and has therefore shown a willingness to engage with these NMC proceedings. Ms Denholm accepted that at this time, [PRIVATE].

Ms Denholm submitted that a conditions of practice order would address the risk to patient safety and satisfy the wider public interest. She submitted that a fully informed member of the public would consider that imposing a conditions of practice order is a proportionate response to the concerns. She submitted that imposing this order for a period of 12 months would, if Ms Beck did decide to return to nursing, allow her the opportunity to find employment, to comply with the conditions of practice order, to strengthen her practice and to provide evidence of safe and effective practice.

Ms Denholm submitted that a suspension order or a striking-off order would be disproportionate and inappropriate in the circumstances of Ms Beck's case, as her misconduct did not require temporary removal from the register or was not fundamentally incompatible with remaining on the register.

Decision and reasons on sanction

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

The panel considered the following aggravating feature in this case:

- Ms Beck's misconduct put patients at risk of suffering harm

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

- Ms Beck's good character and previous good practice.
- [PRIVATE].
- The night of the incident was the first occasion Ms Beck had attended the Home and she was not familiar with the layout of the Home or the patients in the Home.
- Ms Beck's misconduct occurred on one shift at the Home, notably, Christmas eve and the morning of Christmas day.
- [PRIVATE].
- Ms Beck has fully engaged with these NMC proceedings [PRIVATE].

The panel next considered Ms Beck's current level of insight, noting that Ms Denholm has invited the panel to consider this as an aggravating feature. Whilst the panel acknowledged Ms Beck had partial insight into her misconduct, she has not articulated what she would have done differently or the impact of her actions on patients, colleagues and the public. However, it bore in mind that Ms Beck has been unrepresented throughout these proceedings and that she is [PRIVATE].

The panel took into account Ms Beck's contemporaneous email dated 29 December 2020, sent to the Business Centre Manager in response to the concerns raised by the Home. The panel was of the view that in this email Ms Beck had made it clear she had attempted to give all medications to the residents at the Home. The panel also noted that Ms Beck, with hindsight, had accepted she had made mistakes and that [PRIVATE]. Ms Beck was able to articulate her motivation to attend work on 24 December 2020 in her email dated 6 July 2021. She states:

‘I also felt it would be unfair to cancel this shift at short notice as it would be difficult to replace me on an occasion that is so important for families to spend together. [PRIVATE].’

[…]and deeply regret that I made the unfortunate decision to go into work on 24/12/2020.’

The panel was of the view that Ms Beck’s motives to attend work on the night of the incident were entirely positive, though misguided, and it acknowledged that Ms Beck had now realised that her decision to attend work was wrong.

Taking into consideration Ms Beck’s insight into her decision to attend work, her admissions to her mistakes, lack of representation and personal mitigation [PRIVATE], the panel did not identify Ms Beck’s limited insight as an aggravating feature.

The panel first considered whether to take no action but decided that this would be inappropriate in view of its conclusion that there are public protection and public interest issues in this case.

It then considered the imposition of a caution order, 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 whilst the circumstances of this case are at the lower end of the spectrum of impaired fitness to practise, in view of the public protection and public interest it had identified, an order that did not restrict Ms Beck’s practice would not be appropriate or proportionate.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *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 considered that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel was of view that the issues identified could be addressed through supervision and that this order would allow Ms Beck to evidence a period of safe and effective practice. Further, the panel considered that a conditions of practice order would meet the public interest, Ms Beck would be able to continue practising as a nurse if she wishes to return, and as there is no evidence of general incompetence or attitudinal issues, the public would be adequately protected by the imposition of appropriate conditions.

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

Accordingly, the panel imposed a conditions of practice order for the period of 2 years. The panel considered that such a period of time would afford Ms Beck the opportunity to [PRIVATE] and enable her to seek employment as a registered nurse, if she wishes to do so.

The panel was of the view that to impose a suspension order would be disproportionate and would not be a reasonable response in the circumstances of Ms Beck's case. The panel noted that the great majority of charges were not found proven, and considered that the two areas of concern, namely medicines administration and record keeping, can be effectively addressed by appropriate conditions. It did not consider that it was necessary to remove Ms Beck from the register, albeit temporarily.

It follows that a striking-off order would be completely disproportionate and inappropriate.

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

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

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

1. You must not undertake the following tasks unless directly supervised by another registered nurse until you are assessed by your line manager/supervisor as competent to do so:

- Medication management
- Medication administration
- Record keeping

2. Prior to any review, you must send a report to the NMC from your line manager/ supervisor or their nominated deputy evidencing your competence regarding medication management, medication administration and record keeping.

3. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

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

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

5. You must immediately give a copy of these conditions to:
a) Any organisation or person you work for.
b) Any employers you apply to for work (at the time of application).
c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
d) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

6. 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.

7. 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 panel would remind Ms Beck that she may apply for an early review if there is a material change in circumstances, particularly if full compliance with condition 1 and condition 2 has been achieved before the end of the two-year term.

Before the order expires, a panel will hold a review hearing to see how well Ms Beck has 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.

This will be confirmed to Ms Beck in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interest until the substantive conditions of practice order takes effect.

The panel accepted the advice of the legal assessor.

Submissions on interim order

Ms Denholm submitted that an interim conditions of practice order for a period of 18 months is necessary to protect the public and is otherwise in the public interest during the 28-day appeal period and until any appeal that may be lodged is concluded.

Decision and reasons on interim order

In reaching this decision, the panel had regard to the facts found proved and the reasons set out in its decision for the substantive order. The panel was satisfied that an interim order is necessary to protect the public and is otherwise in the wider public interest.

The panel concluded that in this case, 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 and for a period of 18 months to cover the period of any potential appeal.

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

That concludes this determination.