Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Meeting
Wednesday, 26 September 2023

Virtual Meeting

Name of Registrant:	**Paulo Miguel De La Cruz**
NMC PIN	17K0175O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – November 2017
Relevant Location:	Belfast
Type of case:	Lack of competence
Panel members:	Richard Youds (Chair, Lay member) Anna Ferguson (Registrant member) Mary Golden (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Hamizah Sukiman
Order being reviewed:	Suspension order (12 months)
Fitness to practise:	Impaired
Outcome:	**Striking-Off order to come into effect on 10 November 2023 in accordance with Article 30 (1)**

Decision and reasons on service of Notice of Meeting

The panel noted at the start of this meeting that the Notice of Meeting had been sent to Mr De La Cruz's registered email address by secure email on 8 August 2023.

The panel took into account that the Notice of Meeting provided details of the review, that the review meeting would be held no sooner than 25 September 2023, and inviting Mr De La Cruz to provide any written evidence seven days before this date.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr De La Cruz has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (as amended) (the Rules).

Decision and reasons on review of the current order

The panel decided to impose a striking-off order. This order will come into effect at the end of 10 November 2023 in accordance with Article 30(1) of the Nursing and Midwifery Order 2001 (as amended) (the Order).

This is the second review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 12 October 2021. This was reviewed on 3 October 2022 and the panel extended the suspension order by 12 months.

The current order is due to expire at the end of 10 November 2023.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved by way of admission which resulted in the imposition of the substantive order were as follows:

'That you, a Registered Nurse, between November 2017 and December 2018 failed to demonstrate the necessary level of skill and judgment required as a Band 5 nurse.

1. *Between 21 December 2017 and 29 December 2017 in relation to medicines management:*

   1.1. *Did not provide tablets to patients a timely manner -* ***proved by admission***

   1.2. *Were about to give 4mg of warfarin when the prescribed dose was 3mg -* ***proved by admission***

   1.3. *Were about to give insulin to a patient with a pen without prepared the pen correctly -* ***proved by admission***

2. *Between 21 December 2017 and 29 December 2017 in relation to prioritization and providing adequate care:*

   2.1. *Did not pick up the pieces of a broken cup -* ***proved by admission***

   2.2. *Allowed the patient to pick up the pieces of a broken cup -* ***proved by admission***

   2.3. *Did not carry out observations in a timely manner -* ***proved by admission***

3. *Between 21 December 2017 and 29 December 2017 did not carry out infection control -* ***proved by admission***

4. *Between 21 December 2017 and 29 December 2017 did not complete notes in a timely manner -* ***proved by admission***

5. *Between 21 December 2017 and 29 December 2017 did not acknowledge verbal feedback from colleague 1 -* ***proved by admission***

6. *On 22 January 2018:*

6.1. *Gave a patient thin fluids when the patient was on a soft diet and thickened fluids - **proved by admission***

6.2. *Did not carry out the handover - **proved by admission***

7. *Between 28 February 2018 and 25 April 2018 whilst subject to an informal capability process:*

7.1. *On 4 March 2018 in relation to medicines management put 300mg aspirin in cup to be dispensed when the prescribed amount was 75mg - **proved by admission***

7.2. *On 6 March 2018 in relation to medicines management did not give medication as per the kardex - **proved by admission***

7.3. *On 6 March 2018 in relation to prioritization and providing adequate care:*

7.3.1. *Took a blood sample when you were not supposed to - **proved by admission***

7.3.2. *Did not prioritize a DNAR patient - **proved by admission***

7.4. *On 6 March 2018 displayed poor communication skills with patients in that you asked mostly closed questions - **proved by admission***

7.5. *On or before 24 March 2018 in relation to medicines management:*

7.5.1. *Dispensed a drug during the 7am drug round which was due to be dispensed during the 10pm drug round - **proved by admission***

7.5.2. *Did not notify a member of staff that a bottle of controlled drugs had been broken - **proved by admission***

8. *Between 25 April 2018 and 23 October 2018, whilst subject to a formal stage 1 capability process:*

8.1. On 14 July 2018 in relation to prioritization and providing adequate care:

8.1.1. Did not act in a timely manner when requesting blood for a patient who required it - ***proved by admission***

8.1.2. Did not exercise your clinical judgment when removing a catheter from a patient - ***proved by admission***

8.2. On 7 July 2018:

8.2.1. Hung an IV drip without having undergone the required training - ***proved by admission***

8.2.2. Did not take any action in relation to a patient who was visibly upset - ***proved by admission***

8.3. On 29 July 2018 took observation trolleys into two rooms of patients who had clostridium difficile which was against the Trusts infection control policy - ***proved by admission***

8.4. On 29 July 2018 did not fully complete the blood transfusion form for a patient - ***proved by admission***

8.5. On 21 August 2018 in relation to medicines management did not complete the morning medication round in a timely manner - ***proved by admission***

8.6. On 30 August 2018 in relation to prioritization and providing adequate care did not set a patient up for post-op thoracic - ***proved by admission***

8.7. On 13 September 2018 in relation to prioritization and providing adequate care did not escalate patients who required further medical assistance - ***proved by admission***

8.8. *On 25 September 2018 gave priority to a patient who required cannulating instead of a patient who required assistance with toileting -* ***proved by admission***

8.9. *On 6 October 2018 in relation to prioritization and providing adequate care did not assist a patient back to his bed -* ***proved by admission***

8.10. *On 6 October 2018 proceeded to take blood from a patient with un-sanitized hands -* ***proved by admission***

8.11. *On 9 October 2018 in relation to adhering cross infection control did not wash your hands prior to dressing a patients wounds -* ***proved by admission***

8.12. *On 15 October 2018 in relation to prioritization and providing adequate care did not carry out the 2pm observations on a patient when requested to do so -* ***proved by admission***

8.13. *On 16 October 2018 in relation to medicines management did not have a system in place for carrying out a medication round -* ***proved by admission***

9. *On an unknown date did not assist an unknown patient who had just come out of heart surgery despite being asked to do so by a colleague -* ***proved by admission***

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

The original panel determined the following with regard to impairment:

'The panel determined that patients were put at significant risk of harm as a result of Mr De La Cruz's lack of competence. It noted that the facts found proved demonstrate wide-ranging concerns with various aspects of Mr De La Cruz's practice which were repeated over a sustained period of time. The panel considered

that it is likely only the high level of supervision that Mr De La Cruz was subject to that prevented serious harm being caused. Further, the concerns with Mr De La Cruz's lack of competence continued to be raised despite substantial supervision and training from the Trust. The panel found that Mr De La Cruz appeared unwilling or unable to comply with Trust policies and procedures even after these had been explained to him. It considered the facts found proved to demonstrate the fundamental failings of the role of a registered nurse.

As a result of putting patients at risk of harm, the panel determined that Mr De La Cruz's lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It considered that public confidence in the profession, and the NMC as its regulator, would be damaged if no finding of impairment was made in a case involving such wide-ranging and repeated competency concerns.

While the panel noted that Mr De LA Cruz had made admissions to all the charges, it did not consider him to have demonstrated any substantial insight into his actions or understanding of how he put patients at a risk of harm. Further, the panel had no evidence before it to demonstrate that Mr De La Cruz had taken steps to address his lack of competence or the issues raised with his practice. It had no information before it to confirm Mr De La Cruz's current employment status and whether or not he is practising as a registered nurse. The panel also considered that Mr De La Cruz's unwillingness to take any feedback on board demonstrated an attitudinal concern.

With regard to all the above, the panel determined that a finding of impairment is necessary on the grounds of public protection.

The panel considered that a well-informed member of the public would be concerned to hear of a nurse facing such wide ranging concerns with their nursing abilities. It therefore determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel determined that Mr De La Cruz's fitness to practise is currently impaired'

The first reviewing panel determined the following with regard to sanction:

'The panel next considered whether a conditions of practice on Mr De La Cruz's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness and wide-ranging nature of the facts found proved at the original hearing. The panel determined that patients were put at significant risk of harm as a result of Mr De La Cruz's lack of competence. It noted that Mr De La Cruz has not demonstrated any insight into his failings nor taken steps to strengthen his practice and that a conditions of practice order would not be workable. The panel noted that despite being on a capability plan Mr De La Cruz was unable to practise safely and therefore could not be satisfied that a conditions of practice order would adequately protect the public or satisfy the public interest. The panel was not able to formulate conditions of practice that would adequately address the concerns relating to lack of competence.

The panel considered the imposition of a further period of suspension.

The panel concluded that a further suspension order would be the appropriate and proportionate response and would afford Mr De La Cruz adequate time to further develop his insight and take steps to strengthen his practice. The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined to impose a suspension order for the period of 12 months, which would provide Mr De La Cruz with a further opportunity to fully reflect in relation to his failings, provide him with time to complete any training in relation to the areas of concern highlighted at the substantive hearing before the next review hearing. It considered this to be the most appropriate and proportionate sanction available.'

Decision and reasons on current impairment

This panel has considered carefully whether Mr De La Cruz's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether Mr De La Cruz's fitness to practise remains impaired.

The panel noted that there has been no communication from Mr De La Cruz since the last review, and that he has not submitted any written evidence of insight or remediation. The panel had no information before it that suggests that Mr De La Cruz has taken any steps to strengthen his practice, either in terms of training, reflection or employment.

The last reviewing panel determined that Mr De La Cruz was liable to repeat matters of the kind found proved. Today's panel has received no new information which alters that view. The panel considered that there was a risk of real harm, which Mr De La Cruz has made no effort to address. In light of this the panel determined that Mr De La Cruz is liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel concluded that a well-

informed member of the public would be concerned if Mr De La Cruz was allowed to practise without restriction. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that Mr De La Cruz's fitness to practise remains impaired.

Decision and reasons on sanction

Having found Mr De La Cruz fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the subsequent public protection concerns. 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 Mr De La Cruz's 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 Mr De La Cruz's misconduct was 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 a conditions of practice on Mr De La Cruz's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved at the original hearing and concluded that

a conditions of practice order would not adequately protect the public or satisfy the public interest. The panel was not able to formulate conditions of practice that would adequately address the concerns relating to Mr De La Cruz's lack of competence. The panel noted the extensive support that Mr De La Cruz received from his employer in an attempt to address his lack of competence. This included informal and formal capability plans and ongoing workplace support. The panel concluded that those attempts were unsuccessful, which would suggest that conditions imposed on Mr De La Cruz would not adequately address the public protection and public interest concerns.

The panel next considered imposing a further suspension order. The panel noted that Mr De La Cruz has not demonstrated any insight into his previous failings. The panel considered Mr De La Cruz has not provided evidence of addressing the concerns, or any evidence of retraining and strengthening of his practice. The panel also considered Mr De La Cruz's lack of meaningful engagement with his regulator throughout the process, and no engagement at all since the last review. The panel decided the attitudinal issues Mr De La Cruz has displayed appear deep seated when taking into account his failure to complete the capability procedures, his relationship with staff as heard by the original panel, as well as his unwillingness to take constructive feedback from his colleagues, and his disengagement from the regulator. The panel acknowledged Mr De La Cruz's initial unfamiliarity with UK nursing procedures but determined that he was unable to address his lack of competence on aspects of basic nursing skills despite extended support from his employer.

The panel considered, in depth, whether a suspension order would be the most appropriate sanction. However, the panel determined that considerable evidence would be required to show that Mr De La Cruz no longer posed a risk to the public and demonstrated a change in his attitude. The panel determined that a further period of suspension would not serve any useful purpose in all of the circumstances. The panel determined that it was necessary to take action to prevent Mr De La Cruz from practising in the future and concluded that the only sanction that would adequately protect the public and serve the public interest was a striking-off order.

This striking-off order will take effect upon the expiry of the current suspension order, namely the end of 10 November 2023 in accordance with Article 30(1).

This decision will be confirmed to Mr De La Cruz in writing.

That concludes this determination.