Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting

Friday, 23 February 2024 – Tuesday, 27 February 2024

Virtual Meeting

Name of Registrant:	**Rosalinda Monsanto Sumicad**
NMC PIN	03G0966O
Part(s) of the register:	RN1, Registered Nurse – Adult (21 July 2003)
Relevant Location:	Newcastle
Type of case:	Misconduct
Panel members:	Gregory Hammond (Chair, lay member) Jane Jones (Registrant member) Busola Johnson (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Yewande Oluwalana
Facts proved:	Charges 1, 2, 3, 4
Facts not proved:	Charges 5, 6
Fitness to practise:	Impaired
Sanction:	**Suspension order (4 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Sumicad's registered email address by secure email on 19 January 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations and the fact that this meeting would be held virtually no earlier than 23 February 2024.

In the light of all of the information available, the panel was satisfied that Mrs Sumicad 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).

Details of charge

That you, a registered nurse;

1. On 22 October 2019 failed to obtain a prescription for Resident A's docusate sodium after it ran out. **[Proved]**

2. On 22 October 2019 failed to handover that Resident A's prescribed docusate sodium had run out. **[Proved]**

3. On 8 December 2019 failed to follow PRN protocols after administering insulin to Resident B and/or Resident C. **[Proved]**

4. On 8 December 2019 failed to consult a diabetic nurse specialist for advice in relation to Resident B's escalating blood sugar levels. **[Proved]**

5. On 8 December 2019 failed to record the administration of insulin in the medication administration record (MAR) charts for Residents B and/or Resident C. **[Not Proved]**

6. On a date in December 2019 failed to record when PRN medication had been administered in relation to Resident D. **[Not Proved]**

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

Background

On 27 March 2020, the Nursing and Midwifery Council received a referral from BKR Care Consultancy raising concerns in relation to Mrs Sumicad's failure to keep accurate records and follow appropriate protocols.

The charges arose whilst Mrs Sumicad was employed as a staff nurse at Kenton Manor Care Home (Home) from 4 September 2018 until she resigned on 10 January 2020. The Home provided both residential and nursing care to residents, including those with dementia.

On 7 August 2019, the registered manager of the Home at the time sent staff including Mrs Sumicad a 'Letter of Concern' specifically related to medication issues within the Home. This letter instructed staff to improve their practice "to ensure a robust system for medication is in operation".

Following a routine Care Quality Commission (CQC) inspection on 7 October 2019, the Home was rated Inadequate. The CQC found the Home was not well led and that there was a lack of oversight by the registered manager. The Home was underperforming. The main clinical issues related to medication management and the management of diabetes. As a result, BKR were commissioned to manage the day to day running of the Home. Mrs Sumicad was responsible for medication administration, care planning and delegation, and management of staff on a particular unit of the Home.

On 11 October 2019, it is alleged that Mrs Sumicad was involved in an incident concerning Resident A, who was an insulin dependent diabetic and had epilepsy. Resident A was prescribed a daily dose of a laxative, docusate sodium, in the morning and night time to prevent their constipation. During the night shift, Mrs Sumicad realised that Resident A had run out of their prescribed docusate sodium, and recorded this in their Medication Administration Record (MAR) chart stating “out of stock”. It is alleged that Mrs Sumicad then failed to call the Home’s pharmacy and/or the Home’s GP to order a new prescription. It is also alleged that Mrs Sumicad failed to handover to the staff nurses coming on duty for the day shift the information that Resident A’s prescribed docusate sodium had run out so that they could action the request for a new prescription. As a consequence of this failure and that of several other nurses, Resident A did not receive their prescribed dose of docusate sodium for six days which placed them at risk of constipation and possible seizures.

On 30 October 2019, Mrs Sumicad attended a formal investigatory meeting. Mrs Sumicad accepted that she had failed to contact the Home’s pharmacy and GP, and then failed to hand this over to the day shift. Mrs Sumicad accepted that she had made a mistake and apologised for this oversight.

On 5 November 2019, Mrs Sumicad attended a disciplinary hearing. Mrs Sumicad explained that, upon checking the back of Resident A’s MAR chart, she realised that the laxative was out of stock, and failed to contact the pharmacy and address this in the handover, stating she was “really sorry” and accepted this was bad practice.

Following the disciplinary hearing Mrs Sumicad undertook further training in Medication Safety on 12 November 2019 and Diabetes Awareness on 13 November 2019. She passed both courses.

On 29 November 2019, the Home wrote to Mrs Sumicad informing her that due to the seriousness of the incident involving Resident A, she had been given a first and final written warning lasting 12 months.

Further concerns arose in December 2019 in relation to Mrs Sumicad’s medication practice. It is alleged that, in respect of Residents B and C, Mrs Sumicad having noted

their blood sugar levels were over 20 administered Novarapid insulin to Resident C and it was not clear whether she administered insulin to Resident B. However, it is alleged she then failed to follow PRN protocols by assessing blood sugar levels every two hours rather than continuing the routine monitoring. In addition, in the case of Resident C, she did not check if the insulin had been effective in lowering their blood sugar levels. It was also alleged that Mrs Sumicad failed to inform the diabetic nurse specialist about Resident B's rising blood glucose levels in line with PRN protocol.

It is alleged that Mrs Sumicad, on an unknown date in December 2019, failed to sign Resident D's MAR chart after administering Novarapid insulin and also failed to record on the back of Resident D's MAR chart when PRN medications were administered.

Mrs Sumicad was suspended pending an investigation. On 10 January 2020 a local disciplinary hearing was held where Mrs Sumicad accepted all the allegations that were put to her. She stated they were errors on her part and apologised. Mrs Sumicad resigned verbally at the end of this hearing.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the written representations made by the NMC.

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 had regard to the written statements of the following witness on behalf of the NMC:

- Ms 1: Former Operations Manager of the Home at the time of the alleged incidents.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC.

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

Charge 1

"*That you, a registered nurse;*

1. *On 22 October 2019 failed to obtain a prescription for Resident A's docusate sodium after it ran out."*

This charge is found proved.

In reaching this decision, the panel took into account Resident A's MAR Chart and medication notes, the investigation meeting notes from 30 October 2019, and disciplinary meeting notes from 5 November 2019.

The panel had sight of Resident A's MAR chart and noted that on six separate occasions, between 21 October 2019 and 27 October 2019, the medication docusate sodium had not been administered to Resident A by several of the nursing staff. Resident A's medication notes reflected the same as the MAR chart, and "out of stock" was written on the notes. It noted that on 30 October 2019 an investigation meeting was held with Ms 1 and Mrs Sumicad, during this investigation the MAR chart was shown to Mrs Sumicad where she admitted to writing "out of stock" on one occasion on the MAR chart on 22 October 2019, which was the second of nine occasions when this was written. The panel considered the following from the meeting notes:

> '[Ms 1] - *(pointing to signatures) is this you*
> *Rose – that is my signature on 22/10/2019 the other is not mine*
> [Ms 1] – *you have stated only one is yours*
> *Rose – yes*
> [Ms 1] – *can I ask why you did not inform the day nurse or write it in the diary to get more stock.*

Rose – I am sorry I over looked it
[Ms 1] – *why did you not get any stock*
Rose – it was a mistake, I over looked it
…
Rose – I will not put out of stock again without getting a supply of medication.'

The panel noted that at the investigation meeting Mrs Sumicad understood the risks that her oversight had presented to Resident A and that she was tearful and remorseful.

The panel found that at the disciplinary meeting on 5 November 2019, Mrs Sumicad repeated her admissions to the allegations put to her and that she had accepted she had a duty to obtain Resident A's prescription. Taking everything into consideration, the panel found this charge proved.

Charge 2

"That you, a registered nurse,

2. *On 22 October 2019 failed to handover that Resident A's prescribed docusate sodium had run out."*

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's witness statement and the disciplinary meeting notes from 5 November 2019.

The panel had regard to the following from the disciplinary meeting minutes:

'[Ms 2] *Rose this is a disciplinary meeting regarding allegations of docusate ~ can you explain what happened?*

RS I saw the Mar and turned it over, someone had wrote on the back. It was my mistake I did not check the supply. I put out of stock but forgot to write it down for the shift handover.'

The panel considered the fact that Mrs Sumicad made a full admission at the internal disciplinary meeting, and it, therefore, finds this charge proved.

Charge 3

"That you, a registered nurse,

3. On 8 December 2019 failed to follow PRN protocols after administering insulin to Resident B and/or Resident C*."*

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's witness statement, Resident B's and Resident C's PRN protocols, Resident B's and Resident C's diabetic records, and the disciplinary meeting notes from 10 January 2020.

The panel noted that at the investigation meeting on 20 December 2019 Mrs Sumicad stated "*I should have followed the protocol to monitor blood sugar level*" [sic].

The panel further noted that, at the disciplinary meeting on 10 January 2020, the specific allegations relating to the above charge were put to Mrs Sumicad. During this meeting, she admitted to the allegations and outlined the context during which she had made the mistake, namely that Ms 4, the deputy home manager, had shouted at her three times that day and that she felt "*bullied, confused and distracted*".

The panel had sight of Resident B's PRN protocol for when insulin would need to be administered. Resident B's protocol was clear that if their blood glucose level was above 20 then two units of Novorapid would need to be administered. Regular checks would need to be done after two hours. When looking at Resident B's diabetic record Mrs Sumicad saw Resident B at 12:34 on 8 December 2019 and recorded that Resident B's blood glucose was 28.0. If Resident B's protocol had been followed, Mrs Sumicad would have had to check on Resident B within two hours which would have been around 14:34. However the diabetic records show that Mrs Sumicad saw the resident at 16:35 which was over four hours later than was required under Resident B's PRN protocol and the record also showed that she recorded blood glucose levels simply as '*Hi'.*

The panel went on to consider whether the PRN protocol was followed for Resident C. It noted that Resident C's PRN protocol stated that four units of Novorapid were to be administered if Resident C's blood glucose level was above 20. Resident C was to be monitored closely and their blood glucose level to be re-checked after 30 minutes. The expectation was that their blood glucose level should start to lower. The nurse was supposed, under the PRN protocol, to monitor and re-check blood glucose level every two hours.

The panel noted on Resident C's diabetic record for 8 December 2019 that Novorapid was given at 12:45 when their blood glucose level had been recorded as 20.1 and at 16:30 when their blood glucose level was recorded as 23.3. The time between checks was over three hours. The panel noted that Resident C was not checked within the time frame of 30 minutes or at the two hour intervals as required by their PRN protocol.

The panel considered all the evidence before it and determined that Mrs Sumicad on 8 December 2019 failed to follow the PRN protocols for both Resident B and Resident C. The panel therefore finds this charge proved.

Charge 4

"That you, a registered nurse,

4. On 8 December 2019 failed to consult a diabetic nurse specialist for advice in relation to Resident B's escalating blood sugar levels.*"*

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's witness statement, Resident B's PRN protocol, Resident B's diabetic record, and the disciplinary meeting notes from 10 January 2020.

The panel considered, from the notes of the disciplinary meeting, that the specific allegation '*Failing to follow PRN protocol for Novorapid insulin for* [Res B] *and failing to*

inform [the] *diabetic nurse specialist of his escalating blood glucose levels'* was put to Mrs Sumicad and she responded as follows:

> *'RS Yes, I accept my mistakes and apologise.*
>
> [Ms 1] *So you accept the allegations?*
>
> *RS Yes, I feel I didn't upset the residents and that they did not come to any harm'*

The panel, having found Charge 3 proved that the Resident B's PRN protocol was not followed by Mrs Sumicad, also had sight of Resident B's diabetic record. It noted that on 8 December 2019, Resident B's blood glucose level was elevated at 12:34 when it was recorded as 28.0, and at 16:35 it was recorded as *'Hi'.* Despite the PRN protocol for Resident B stating that the diabetic nurse or alternative medical assistance should have been called if the blood glucose level had not been lowered below 20.0 within two hours, this was not done by Mrs Sumicad. The panel noted that a diabetic nurse was contacted by another colleague a day later on 9 December 2019. The panel considered that had Mrs Sumicad contacted the diabetic nurse, she would have recorded it similarly on Resident B's diabetic record. The absence of such a record by Mrs Sumicad is supporting evidence that she did not contact the diabetic nurse.

In light of the evidence before the panel, it determined that Mrs Sumicad's admissions, Resident B's PRN protocol and their diabetic record to be sufficient evidence to find this charge proved. The panel therefore found on the balance of probabilities that this charge is proved.

Charge 5

> *'That you, a registered nurse,*
>
> 5. *On 8 December 2019 failed to record the administration of insulin in the medication administration record (MAR) charts for Residents B and/or Resident C.*

This charge is found NOT proved.

In reaching its decision the panel noted that this allegation was not put to Mrs Sumicad during any of the internal meetings. The panel considered that the NMC did not provide evidence of Resident B's or Resident C's MAR charts. The panel found that there was a lack of any corroborating evidence in the absence of the MAR charts. In the absence of evidence in relation to this charge, the panel was not satisfied that the NMC had discharged its duty to prove the allegation on the balance of probabilities. The panel therefore found this charge not proved.

Charge 6

'That you, a registered nurse,

6. On a date in December 2019 failed to record when PRN medication had been administered in relation to Resident D.'

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 1's witness statement, the investigation minutes from 20 December 2019, Resident D's medication notes and MAR chart.

The panel noted that the charge did not identify any specific dates on which it alleged that Mrs Sumicad did not record when Resident D's PRN medication had been administered. The panel considered that Mrs Sumicad's admissions at the disciplinary meeting on 10 January 2020 were general in that four allegations were put to her together in one go, and she seems to have made a global acceptance of those allegations together. There was no evidence that Resident D's charts were put to her specifically for comment. The panel was not satisfied that Mrs Sumicad's admissions were sufficiently clear or specific to cover the allegation in this charge.

The panel had sight of Resident D's MAR chart for December 2019 and noted that there was a large number of signatures for PRN medication administration. There was no separate handwriting evidence that showed Mrs Sumicad's signature. The panel could not therefore be satisfied that Mrs Sumicad's signature was not one of those on the chart.

There was no evidence provided by the NMC of Resident D's PRN protocol or that they needed the PRN medication. Further the NMC did not provide any evidence to prove that Mrs Sumicad was on duty at the times of the PRN medications being recorded nor whether she was responsible for administering the PRN medications.

On the balance of probabilities, the panel therefore found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mrs Sumicad'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 ability to practise kindly, safely and professionally.

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

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

Representations on misconduct and impairment

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

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and *Nandi v General Medical Council [2004] EWHC 2317 (Admin).*

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

The NMC identified breaches of the specific, relevant standards as follows: 1.2, 1.4, 2.1, 6.2, 8.2, 8.2, 9.2, 10, 10.1, 10.2, 10.3, 10.4, 10.5 and 10.6.

The NMC made the following written representations in relation to misconduct:

> '*We consider the misconduct serious because it involves a considerable number of serious medication errors in a short space of time, even after training and local intervention. The errors, in spite of this, gave rise to a real risk of harm to the public on numerous occasions.'*

The NMC invited the panel to find Mrs Sumicad's fitness to practise impaired on the grounds that:

> *'We note Ms Sumicad has not worked since the issues of concern. We consider there is a continuing risk to the public due to Ms Sumicad's lack of full insight/failure to undertake relevant/sufficient relevant training/having not had the opportunity to demonstrate strengthened practice through work in a relevant area. In our view, Ms Sumicad is currently a risk to the health, safety or wellbeing of the public and her practice needs to be restricted in some way.*
>
> *…*
>
> *We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Ms Sumicad's conduct engages the public interest because*

despite training and local intervention, she has committed several serious medication errors in a short space of time which had the potential to cause unwarranted risk of harm to patients. The public rightly expect nurses to perform their duties safely and professionally, and as such, the absence of a finding of impairment risks undermining public confidence in the profession.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

The panel was of the view that Mrs Sumicad's actions, taken together, did fall short of the standards expected of a registered nurse, and that Mrs Sumicad's actions amounted to a breach of the Code, specifically:

'***1.2*** *make sure you deliver the fundamentals of care effectively*

1.4 *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

2.1 *work in partnership with people to make sure you deliver care effectively*

8 Work cooperatively

8.2 *maintain effective communication with colleagues*

8.3 *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

8.5 *work with colleagues to preserve the safety of those receiving care*

__8.6__ share information to identify and reduce risk '

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered the charges individually and collectively to determine whether Mrs Sumicad's actions amounted to serious misconduct.

The panel considered charges 1 and 2 but found that Mrs Sumicad's actions did not cross the threshold of seriousness individually. The panel was mindful that medications management was an area of concern at the Home and that Mrs Sumicad was not the only nurse involved with this failure. It noted that a first and final warning regarding medication management was issued in July 2019. However, the panel determined that the conduct in charges 1 and 2, taken by themselves, could be considered as isolated mistakes due to poor practice rather than serious misconduct.

The panel considered charges 3 and 4 and found these to be serious. It noted that on Resident B's diabetic record, Mrs Sumicad inappropriately wrote *'Hi'* for Resident B's blood glucose level rather than recording a numerical blood glucose level. It is not a trivial matter for a resident to have a high blood glucose level. The protocols in place to address the concern were not followed nor the appropriate action taken. By not following the protocols, the panel considered Mrs Sumicad to be complacent and to have put patients at risk of significant harm.

The panel noted that, following the first and final warning issued in July 2019, Mrs Sumicad had undertaken further training in *'Medication Safety training'* on 12 November 2019, and *'Diabetes awareness training'* on 13 November 2019 and that she passed both training days. Following this training, further mistakes were made by Mrs Sumicad in relation to Resident B and Resident C on 8 December 2019.

The panel was of the view that both a fellow registrant and the public would be concerned that a nurse who had just completed training in medication safety and diabetes awareness went on to make further errors within four weeks in these specific areas and put patients at risk of significant harm.

When considering all the charges collectively the panel found that Mrs Sumicad's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to serious misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

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

undermined if a finding of impairment were not made in the particular circumstances.'

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

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

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

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

d) …'

The panel finds that residents were put at risk and may have been caused physical and emotional harm as a result of Mrs Sumicad's poor practice and misconduct. Mrs Sumicad's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel is aware that this is a forward-looking exercise and, accordingly, it went on to consider whether Mrs Sumicad's misconduct was remediable and whether it had been remediated. The panel then considered the factors set out in the case of *Cohen v GMC.*

Regarding insight, the panel considered that at the local investigation in October 2019, the disciplinary meetings in November 2019 and January 2020, Mrs Sumicad expressed remorse and showed insight into the failings and what she would have done differently if a

similar situation were to recur. Mrs Sumicad accepted the mistakes when they were brought to her attention and Ms 1, in her witness statement, stated that Mrs Sumicad was remorseful and very tearful.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel considered the evidence before it in determining whether or not Mrs Sumicad has taken steps to strengthen her practice. The panel noted that there was no further evidence from Mrs Sumicad regarding any training she had undertaken to strengthen her practice since the incidents in December 2019 and that she has disengaged from the regulatory process. The last contact with the NMC by Mrs Sumicad was on 15 April 2020.

Mrs Sumicad has not engaged with these proceedings. She has not provided an account or explanation of what happened since the local investigation and disciplinary meetings, and neither has she responded to any communications from the NMC other than to say she is no longer in the nursing profession. The panel noted Mrs Sumicad's early admissions in the local investigation and disciplinary meetings, which indicated some acknowledgment of her failings but as she has not engaged, the panel could not determine the level of her current insight.

In light of this, the panel is of the view that there is a risk of repetition. Mrs Sumicad was issued a first and final warning for 12 months concerning medications management failures (Charges 1 and 2) on 22 October 2019. She undertook further training on 12 and 13 November 2019 in medication safety and diabetes awareness. Following this training, further incidents occurred on 8 December 2019 (Charges 3 and 4) in relation to medications and diabetes management. Residents' blood glucose levels were not being monitored in accordance with the protocols. Mrs Sumicad has not worked as a registered nurse since 2020 and there is nothing before the panel today that indicates that Mrs Sumicad has addressed the concerns. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Sumicad's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Sumicad's fitness to practise is currently impaired.

Sanction

The panel has considered this case carefully and has decided to make a suspension order for a period of four months with a review. The effect of this order is that the NMC register will show that Mrs Sumicad's registration has been suspended.

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 19 January 2024, the NMC had advised Mrs Sumicad that it would seek the imposition of a six month suspension order with a review, if the panel found all charges proved and that Mrs Sumicad's fitness to practise were currently impaired.

The NMC's written submission included:

> *'Aggravating factors*
> *Various misconduct issues within a short space of time*
>
> *Mitigating factors*

Remorseful and accepts conduct. In April 2020, Ms Sumicad was 71 years of age and decided to retire.

…

The NMC guidance on suspension orders states that this sanction may be appropriate where there is no evidence of a deep seated and/or harmful attitudinal issue. It is submitted that this would be the most appropriate sanction to impose in this case to manage the risk to the public. A 6- month suspension will mark the seriousness of the conduct in the public interest.'

Decision and reasons on sanction

Having found Mrs Sumicad'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 took into account the following aggravating features:

- Conduct which put patients at risk of suffering significant harm.
- Errors in respect of Residents B and C occurred in December 2019 following related training undertaken in November 2019.

The panel noted that Mrs Sumicad was working in an environment where there were systemic and acknowledged failures. Ms 1's witness statement highlighted the following:

'…I do think the culture in the Home contributed to the Nurse's errors as well as the other nurses who were referred to the NMC at the Home.

In light of my experienced [sic] *as a nurse and in my role at the time as Operations Manager of the Home, in my professional opinion I firmly believe a culture of complacency had developed in the Home as* [Ms 3] *was not effectively managing*

systems of addressing issues with nurses. I feel that the nurses were caught up in this culture and it impacted on their practise.'

The CQC carried out an inspection at the Home on 7 October 2019 and published its report on 3 December 2019. The following was stated:

● *People were at serious risk as medicines were not managed safely. Protocols in place for the safe administration of 'as required' medicines were missing from people's records…*

● *People were at risk of receiving medicines in a way they were not prescribed as staff were not following administration guidance…*

● *Medicine care plans were not always in place, did not always include 'as required' medicines and not all information was recorded in the medicine risk assessments.*

● *Clinical staff did not always follow national guidance or pro-actively mitigate risks to people with regards to medicines.*

● *The registered manager and clinical staff took immediate action to address the issues identified but we found that these were not fully addressed.*

The panel considered Mrs Sumicad's comments at the disciplinary meeting on 10 January 2024, when she said

'*I was stressed it was very busy and* [Ms 4] *was shouting at me, three times in one day; I felt bullied, confused and distracted.'*

In light of the above the panel took into account the following mitigating features:

- There was a poor culture at the Home, including poor supervision, as set out above in Ms 1's witness statement, the CQC report and Mrs Sumicad's claims at the disciplinary meeting.
- Mrs Sumicad made informal admissions at the local investigations.
- Mrs Sumicad apologised at all internal meetings.
- Mrs Sumicad had insight into her failings and set out what she would do differently in the future at all internal meetings.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Sumicad'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 Mrs Sumicad'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 placing conditions of practice on Mrs Sumicad'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 took into account the SG for when a conditions of practice order could be appropriate, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that the poor practice and misconduct in this case is capable of being remedied by training, supervision and assessment. However, in Mrs Sumicad's circumstances there are no practicable or workable conditions that could be formulated, given her disengagement and statement that she has retired from the profession. The panel determined that conditions of practice would not be suitable in this instance.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with her remaining on the register. The panel decided that although there had been a clear breach of fundamental tenets of the nursing profession and a departure from a number of the standards in the Code, Mrs Sumicad's misconduct was capable of remediation. The panel could find no evidence of attitudinal concerns or that there was long lasting general incompetence in Mrs Sumicad's practice. The panel noted that it wasn't a single instance, but the incidents occurred on the same day. There has been no repetition since as she resigned from the Home in January 2020 and has retired from nursing. Mrs Sumicad did have insight at a local level about her conduct. However, she still poses a risk of repeating the behaviour.

The panel was of the view that Mrs Sumicad should be afforded the opportunity to demonstrate that she understands the severity of her acts and omissions to a future reviewing panel. The panel had identified that there was a risk of repetition in the absence of any evidence to the contrary. If Mrs Sumicad does decide that she wants to return to the nursing profession and can demonstrate sufficient insight and remediation to a future reviewing panel, it could be in the public interest to retain an experienced registered nurse who has had a lengthy career and is capable of delivering safe and effective nursing practice.

The panel was of the view that a suspension order for four months would provide Mrs Sumicad with sufficient opportunity to reengage with the NMC, and to reflect and develop her insight. She would be able to explain to a future panel why she acted in the way that she had, and the impact that it would have had on residents, the Home and the wider nursing profession. She would also be able to comment on what she will do differently if a similar situation arises in the future.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation found, it concluded that a striking-off order would be disproportionate. Whilst the panel acknowledges that suspension may have a punitive effect, it would be unduly punitive in Mrs Sumicad's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order may cause Mrs Sumicad. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of four months with a review was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

The panel took into account Mrs Sumicad's email dated 15 April 2020, which stated as follows:

‘I would like to inform you that I am not currently working as a nurse in any organisations as I have resigned as a registered nurse from Kenton Manor Care Home effectively January 10,2020. I am not in the process of applying for any nursing roles and I have no longer any intentions of doing so. [PRIVATE]. *I have decided to retire completely and I have decided to go back home* [PRIVATE]*’*

Any future panel reviewing this case would be assisted by:

- A further clear statement of intentions from Mrs Sumicad in relation to any future nursing practice or decision to retire; or
- A reflective piece and evidence of retraining should Mrs Sumicad wish to return to nursing practice.

This will be confirmed to Mrs Sumicad in writing.

Interim order

As the suspension 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 Mrs Sumicad’s own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that *‘If a finding is made that Ms Sumicad’s fitness to practise is impaired on a public protection basis, and a restrictive sanction imposed, we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest’*.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to in order to protect the public and the wider public interest to cover the 28-day appeal period and the duration of any appeal should Mrs Sumicad decide to appeal against the panel's decision.

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

That concludes this determination.