Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 4 August – Wednesday, 6 August 2025
Friday, 8 August – Thursday, 21 August 2025

Virtual Hearing

Name of Registrant:	**Ema Macinoi**
NMC PIN:	15L0084C
Part(s) of the register:	RN1: Registered Nurse – (sub part 1) Adult – Level 1 1 December 2015
Relevant Location:	Birmingham
Type of case:	Misconduct
Panel members:	Mark Gower (Chair, Lay member) Sam Wade (Lay member) Patience McNay (Registrant member)
Legal Assessor:	Charlotte Mitchell-Dunn
Hearings Coordinator:	Hanifah Choudhury (4 August 2025) John Kennedy (5-6 August, and 8-21 August 2025)
Nursing and Midwifery Council:	Represented by Marcia Persaud, Case Presenter
Ms Macinoi:	Present and represented by Jerome Burch, (Royal College of Nursing)
Facts proved:	Charges 1, 2a, 2b, 3a, 3b, 5a, 5b, 5c, 6, 8, 11, 12a, 12b (in full), 12c (in full), 13a (in full), 13b (in full), 14a, 14b, 14c, 15a (in full), 15b, 17a (in full), and 17b (in full)

Facts not proved:	Charges 4, 7, 9a, 9b, 9c, 16a, 16b, 16c, 18a, 18b, and 18c
No case to answer:	Charge 10
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

While working at Arden Grange on 4 February 2023:

1. Failed to ensure only Resident B's medication was in their bag of medication before they were taken to hospital.

2. Failed to administer:

a) Tamoxifen to Resident C;
b) Mebeverine to Resident D.

3. Made an inaccurate record in Resident C's care plan evaluation notes in that you:

a) failed to record that Resident C's Tamoxifen medication was missing;
b) recorded that there were "no issues" in respect of Resident C when you knew Resident C's Tamoxifen medication was missing.

4. Your actions in Charge 3a above were dishonest because you knew that Resident C's medication was missing and you intended to conceal that knowledge.

5. Your actions in Charge 3b above were dishonest because

a) You knew that Resident C's medication was missing
b) You knew that you had recorded a false account in Resident C's record
c) You intended to create a misleading impression that no issues had arisen with Resident C during your shift.

6. Failed to promptly inform permanent and/or senior members of staff of Resident C and/or Resident D's missing medication.

7. Your actions in Charge 6 above were dishonest because you wanted to conceal your knowledge of the missing medication for Resident C and/or Resident D.

8. Gave an inaccurate account to 111 Out of Hours service as to why emergency prescriptions were required for Resident C and/or Resident D.

9. Your actions in Charge 8 above were dishonest because

a) You knew that Residents C and D's medication was missing
b) You knew that the account you gave to 111 was false
c) You intended to create a misleading impression that Residents C & D required an emergency prescription because their medication had run out.

10. Failed to undertake and/or complete temperature checks for refrigerated medication.

11. Failed to check and/or apply a dressing to Resident E's wound.

12. Following Resident I's fall, you

a) failed to carry out a complete post fall check upon Resident I;
b) failed to complete
    i) A post falls assessment tool
    ii) An incident form
    iii) A body map
c) Failed to record Resident I's fall in
    i) The care plan
    ii) The daily notes

While working at Acacia Lodge Care Home on 27 April 2023:

13. In respect of Resident F:

a) Did not administer or offer to administer Resident F's Co-Beneldopa medication at:

i) 14.30
ii) 17.00
iii) 19.30

b) Recorded in Resident F's MAR chart that Resident F had refused their Co-Beneldopa medication when offered to them at:

i) 14.30
ii) 17.00
iii) 19.30

14. Your actions at any or all of Charge 13 b) above were dishonest because

a) You knew that you had not offered Resident F their Co-Beneldopa medication
b) You knew that you had recorded a false account in Resident F's MAR chart
c) You intended to create a misleading impression that Resident F had refused their Co-Beneldopa medication when it had not been offered to them.

Whilst working at Limewood Care Home on 6 May 2023:

15. In respect of Resident G, you:

a) After Resident G's daily dose had already been administered, administered a further dose of the following medication, without clinicial justification:

i) Memantine
ii) Ferrous Sulfate
iii) Colecalciferol

b) Recorded in Resident G's MAR chart that you administered the extra dosages of the medication listed in Charge 15a) i) – iii) above, on 7 May 2023.

16. Your actions at Charge 15b) above were dishonest because:

a) You knew that you had administered this medication to Resident G on 6 May 2023;
b) You knew that you had made a false record;
c) You intended to conceal that you had wrongly administered a second dose of the medication to Resident G on 6 May 2023.

17. In respect of Resident H, you:

a) did not administer Resident H's

i) Lansoprazole tablet
ii) Trimbow inhaler

b) Recorded in Resident H's MAR chart and/or daily records that you had administered:

i) The Lansoprazole tablet:
ii) The Trimbow inhaler

18. Your actions at any or all of Charge 17 b) above were dishonest because:

a) You knew that you had not administered the medication
b) You knew that you had made a false record
c) You intended to create a misleading impression that Resident H had received their medication.

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

Background

The charges arose whilst you were employed as an agency nurse contracted by Acton Banks Agency (the Agency) between April 2022 and May 2023. While contracted by the Agency you undertook placements at Arden Grange (Arden), Acacia Lodge Care Home (Acacia), and Limewood Care Home (Limewood). The allegations involve multiple medication administration errors, including failing to administer medication, administering additional dosages, and failing to adequately check medication stock. There were also concerns that you had allegedly failed to properly escalate patient care concerns, and provided misleading information to Out of Hours emergency services. Additionally, there are allegations that you failed to maintain appropriate records and falsified patient records dishonestly.

In May 2023 you ceased to work for Acton Banks Agency and began working with Omni Health Care agency.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Burch, on your behalf, that there is no case to answer in respect of charges 10 and 12b)ii. This application was made under Rule 24(7).

Mr Burch submitted that with reference to the case of *R v Galbraith* [1981] 1 WLR 1039 the second limb set out therein is engaged in respect of both charges. He submitted that for charge 10 the evidence presented by the Nursing and Midwifery Council (NMC) is inherently weak and tenuous in nature such it should not remain before the panel for consideration. He submitted that the only evidence relates to Witness 1 recounting what was told to them by another witness, and that the fridge sign sheet has not been provided in evidence to support this charge. He submitted that without this crucial sign off sheet the evidence is not sufficient to have a realistic prospect of success of finding charge 10 proved, as it is of a tenuous nature and not sufficient to support the charge that you had a duty to check the fridge nor that you failed in that regard.

Mr Burch submitted that in regard of charge 12b)ii the second limb of *Galbraith* is engaged. He submitted that the evidence presented, including the *'Post Falls Protocol'* indicate that the incident should only be filled out after 24 hours of observation has been completed. He submitted that other evidence presented state that you were not working at the Home the day after this incident and therefore would have been unable to carry out the required 24 hour observations or fill out the incident form. Therefore, he submitted that there is no realistic possibility of this charge being found proved and it should not remain before the panel.

Dr Persaud, on behalf of the NMC, submitted that there is a case to answer in regard to both charges. She submitted in respect of charge 10 the reason the fridge sign off sheet has not been produced in evidence is that it was not completed as would be required if you had completed the check. She submitted that this charge was considered in the oral evidence of Witness 6 who provided evidence that this check was a requirement to be completed and that you had failed to do this. Therefore, she submitted that there is sufficient evidence, that was tested by cross-examination, and there is a realistic prospect of the panel finding charge 10 proved.

Dr Persaud submitted that in regard of charge 12b)ii the panel had heard the oral evidence of Witnesses 1 and 5 who stated that you had not completed the incident form,

but that you were required to do so having witnessed the fall. She submitted that therefore there is evidence that is not tenuous and there remains a realistic prospect of the panel finding this charge proved.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor, which included reference to the NMC guidance DMA-6 and the case of *R v Galbraith* and *R (on the application of Tutin) v General Medical Council* [2009] EWHC 553 (Admin).

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer in respect of charges 10 and 12b)ii.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 10 proved. The panel considered that there is a clear lack of sufficient documentary evidence to show that you had not completed the fridge temperature check. The panel noted that within the policy of the Home it is unclear whether the duty to check was solely the responsibility of the registered nurse on duty at a shift, or if this was something shared by the nurse and carers or healthcare assistants who were working. The panel therefore concluded that there is insufficient evidence that you would have been under a duty. The panel also noted that there is no direct evidence in support of this charge. Therefore, the panel concluded that the evidence presented in support of charge 10 is inherently weak and of such a tenuous nature that there is no realistic prospect of the panel finding it proved. In light of this charge 10 should not remain before the panel for consideration.

The panel then considered the application regarding charge 12b)ii. The panel was of the view that there had been sufficient evidence to support this at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. The panel considered that this is a charge which had been examined in the oral

evidence of multiple witnesses, along with the documentary evidence presented. The panel considered that questions such as, when and how the incident form should be completed are matters that require a probing determination that would require the panel to weigh the evidence presented. The panel noted the guidance at DMA-6 which states that when considering the strength or weakness of the evidence, and what weight should be placed on any evidence, the panel is more likely to consider that there remains a case to answer, in order that the evidence can be fully tested and appropriate weight given. This is something that the panel can only do at the conclusion of all evidence, therefore it rejected the application in respect of charge 12b)ii.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Burch, who informed the panel that you made full admissions to charges 1, 2a, 2b, 3a, 3b, 11, 12c)ii, 13a)iii, 13b)i, 13b)ii, 13b)iii, 15a)i, 15a)ii, 15a)iii, 15b, 17a)i, 17a)ii, 17b)i, and 17b)ii.

The panel therefore finds charges 1, 2a, 2b, 3a, 3b, 11, 12c)ii, 13a)iii, 13b)i, 13b)ii, 13b)iii, 15a)i, 15a)ii, 15a)iii, 15b, 17a)i, 17a)ii, 17b)i, and 17b)ii proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Dr Persaud and by Mr Burch.

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 at Arden Grange Care Home
- Witness 2: Deputy Manager at Acacia Lodge Care Home
- Witness 3: Clinical lead and Limewood Care Home
- Witness 4: Registered Manager at Acacia Lodge Care Home
- Witness 5: Former Team Leader Healthcare Assistant at Arden Grange Care Home
- Witness 6: Nursing Assistant at Arden Grange Care Home

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. In regard to the charges relating to dishonesty the legal assessor referred to the case if *Ivey v Genting Casinos Ltd t/a Crockfords* [2017] UKSC 67. The legal assessor referred the panel to the relevant case law in respect of identification evidence relating to the CCTV evidence. It considered the witness and documentary evidence provided by both the NMC and Mr Burch.

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

Charge 4

"Your actions in Charge 3a above were dishonest because you knew that Resident C's medication was missing and you intended to conceal that knowledge."

This charge is found not proved

The panel considered the live evidence of Witness 6 and yourself on this charge. It noted that you had accepted charge 3a which formed the factual basis for this alleged dishonesty.

The panel considered that while you had failed to record the medication for Resident C was missing both in your account and in the evidence of Witness 6 and the documentary evidence of Witness 1 it is accepted that you did tell the team leader (Witness 6) before the end of the shift. You explained in your oral evidence that you informed the team leader in the morning of one of the medications that were missing and explained the *'O'* entry on the Medication Administration Record (MAR) chart, to indicate '*other*', and stated there was an explanation entry on the back of the form, however, this document is not available. The panel considered that while it may be plausible that you alerted the team leader at 09:00 of one of the missing medications, it noted that in fact two medications were missing that day and there was no report of the second medication. You were not specific about which medication was missing. It found it highly unlikely you would report one missing medication but not the other therefore considering all the evidence preferring the evidence of Witness 6 that you did not report the missing medication at 09:00.

The panel considered your knowledge of the circumstances at the time and the fact that you had made reference to an entry about this medication ('O') on the MAR chart. The panel concluded that although it did not accept your account in respect of reporting the missing medication in the morning, given that you did inform the team leader prior to the end of the shift, and there is an entry in the MAR chart, it is therefore less likely that you were making an attempt to conceal the knowledge of the missing medication.

The panel considered the NMC guidance around dishonesty and found that you had informed the team leader and had made reference to the medication issue in the MAR chart. The panel considered on the basis of your belief around the circumstances at the time an ordinary decent person would not be likely to accept that you were making an attempt to conceal the knowledge of the missing medication. Therefore, the panel concluded that in this charge the dishonest element is not made out and found charge 4 to be not proved.

Charge 5

> "Your actions in Charge 3b above were dishonest because
>
> a) You knew that Resident C's medication was missing
> b) You knew that you had recorded a false account in Resident C's record
> c) You intended to create a misleading impression that no issues had arisen with Resident C during your shift.

This charge is found proved

The panel considered this charge and the subcharges individually and as a whole in reaching its decision and found it to be proved on all charges.

The panel considered that you knew the medication was missing, as you admitted, and despite this made an inaccurate record that there were *"no issues"*. In questioning the panel asked what you would assume if when starting shift you had read in a patients notes that there were *"no issues"*; you replied that you would take that record to mean there had been nothing out of the ordinary with the resident or their care during the shift and that everything was alright with them.

When asked by Mr Burch if you had made a false account you stated that it was the clinical side of resident and nothing medical. You were asked if you thought what you did was dishonest. You responded *'that at that time and policy of the home I should have put on the notes'*, but that you didn't think it was false documentation.
The panel heard from you and the explanation of the '*O*' entry and that there was no indication on the front of the MAR chart indicating the explanation on the rear. You said it was '*common practice'*. There was also a 'gap' in the MAR chart.

The panel interpreted the phrase *"no issues"* to mean exactly that. It noted the ambiguity and gaps in the MAR chart which clearly demonstrate that there were issues which should have been documented. In light of this the panel considered that the phrase *"no issues*" is misleading, inaccurate, and not reflective of your knowledge at the time of making the record.

The panel considered the NMC guidance around dishonesty and found that at the relevant time you knew or believed that there were issues with the resident's medication, which ought to have been brought to the attention of others, and despite this recorded that there were no issues. The panel considered on the basis of your belief around the circumstances at the time, an ordinary decent person, would find the act of writing there are "no issues", despite knowing there were issues to be dishonest. Therefore, the panel concluded that in this charge the dishonest element is made out and found the entirety of charge 5 to be proved.

Charge 6

> "Failed to promptly inform permanent and/or senior members of staff of Resident C and/or Resident D's missing medication."

This charge is found proved

The panel bore in mind its earlier findings at charge 4 that you did inform the senior and permanent staff members about the missing medication on the shift. It bore in mind the evidence of Witness 6 who stated that you informed them around 14:30 when you had become aware of the missing medication on the morning around 09:00.

You told the panel in your oral evidence you alerted the team leader (witness 6) that one of the medications (either Resident C or D) was missing. Witness 6 in their evidence told the panel the missing medication was alerted to them when '*talking to the nurse in reception*' and that this was at around 14:30. The panel had regard to the medication policy and that as a nurse on shift you were under a duty to inform the permanent and senior member of staff of missing medication.

The panel also considered that a minimum of around five hours had elapsed before alerting the team leader as to both the medications being missing.

The panel noted that both Resident's C and D's medication was missing and that would have been known to you as a result of the morning medication round. However, in oral evidence you stated you were only aware of one missing medication. The panel considered that while it may be plausible that you alerted the team leader at 09:00 of one of the missing medications, it noted that in fact two medications were missing and there was no report of the second medication. It found it highly unlikely you would report one missing medication but not the other therefore considering all the evidence preferring the evidence of Witness 6.

In all the circumstances the panel concluded that a delay of at least five hours before reporting the missing medication is not reporting it promptly. Therefore, the panel found this charge to be proved.

Charge 7

"Your actions in Charge 6 above were dishonest because you wanted to conceal your knowledge of the missing medication for Resident C and/or Resident D."

This charge is found not proved

In reaching this decision the panel considered the statements from you and the oral evidence of Witness 1.

The panel considered, on the same evidence as above, that you were not prompt in informing staff about the missing medications; however, you did eventually tell the senior members of staff about the missing medications. The panel considered that when confronted, on the same shift that the medications went missing, you made no attempt to obfuscate or otherwise conceal your knowledge that the medication was missing. Rather you stated that you had been attempting to locate the medication yourself. The panel considered that as you did tell senior members of staff on the same shift that the medication went missing, albeit later than you should have, an ordinary decent person would not consider this an attempt to conceal or cover up your knowledge of the missing medication.

Therefore, while the panel considered that your actions may be poor medication practise in this regard they do not amount to dishonesty, and this charge is found not proved.

Charge 8

"Gave an inaccurate account to 111 Out of Hours service as to why emergency prescriptions were required for Resident C and/or Resident D."

This charge is found proved

The panel considered the emails from the pharmacist and Witness 1 and your oral evidence. These record the information you gave to 111 Out of Hours service that the

residents needed emergency prescription as *“Patient had ordered their prescription but it was not ready*”. On seeing this note the pharmacist and general practitioner (GP) surgery investigated and were concerned that there was a risk of overdosing, or missing medications, as the prescription cycle should not have run short by this time.

In your oral evidence you accepted that you gave inaccurate information to 111 Out of Hours service, in that you did not provide the true reason why the emergency prescription was needed within the online service form, as shown within the pharmacy email. You explained that you believed the online service was quicker to use as opposed to waiting in a queue on a call. You stated that you always get a call back from the 111 service and that when you did, you explained the circumstances.

The panel found that despite your explanation that you intended to give the accurate information at a later stage, the information you initially gave was inaccurate and therefore found this charge proved.

Charge 9

> “Your actions in Charge 8 above were dishonest because
>
> a) You knew that Residents C and D’s medication was missing
> b) You knew that the account you gave to 111 was false
> c) You intended to create a misleading impression that Residents C & D required an emergency prescription because their medication had run out.”

This charge is found not proved

The panel considered these subcharges together as they relate to the same action of alleged dishonesty.

In your oral evidence you stated that the reason given when initially contacting the online 111 Out of Hours service was generated from a list of pre-determined options. You selected the option you believed to most closely reflect the circumstances of why the medication was needed. However, you believed that you would receive a phone call and then be able to explain in detail what the situation really was. You stated that in the past you had always received a phone call to provide more details and had no reason to believe this would not happen this time. You informed the panel that you did not intend to create a misleading impression and that you would have explained the whole situation on the phone.

The panel heard no information to challenge this account provided by you.

The panel considered your knowledge of the circumstances at the time and the fact that you had selected a pre-determined option and intended to provide full details upon a call back from the 111 service. The panel accepted this explanation as plausible given your experience of the 111 service and in the absence of any challenge.

The panel considered the NMC guidance around dishonesty and found that you had provided a plausible explanation for your actions. It also considered an ordinary decent person, would not have found the inaccurate information that you gave to have amounted to you intending to create a misleading impression of why the medication had run out. Therefore, the panel concluded that in this charge the dishonest element is not made out and found charge 9 to be not proved in its entirety.

Charge 12

> “Following Resident I’s fall, you
> a) failed to carry out a complete post fall check upon Resident I;
>
> b) failed to complete
> i) A post falls assessment tool

ii) An incident form
iii) A body map

c) Failed to record Resident I's fall in
i) The care plan"

This charge is found proved

The panel considered these charges individually and as a whole, determining that they are inextricably linked.

The panel gave consideration to the submissions made on your behalf that in order to complete the documentation and the complete post fall check it involved continual observation for 24 hours post fall and that it was for the witness to any fall to report. It was submitted this would not be possible for you to complete as you were not on shift the day following the fall nor were you the witness to the fall. However, the panel considered that it would not be the case that the same nurse would be on shift for a continual 24 hour period following a fall, and therefore in any event there would necessarily be a handover. It considered that therefore in order for the incoming nurse to know they needed to complete the 24 hour post fall observations there must have been an incident form, body map, notes in the care plan, and the post fall assessment tool created by the nurse who was on shift at the time of the fall. Therefore, the panel rejected the submissions regarding your inability to complete this as you were not on shift for the full 24 hours post fall.

The panel had regard to the post fall policy in place at Arden, and noted that you accepted you were aware of this policy. The panel considered that this sets out what must be done following a resident fall and that it provides information on what a complete post fall check is.

The panel considered that the documentation following a fall is a crucial part of the post fall check. It heard evidence from witnesses that they would look for an incident form

(which was largely to be completed by the person who observed the fall but not exclusively their responsibility), a body map, the residents care plan and daily notes, to know that a fall had occurred and what observations would be required during their shift. Therefore, the panel considered that these must have needed to be completed prior to the conclusion of the 24 hour observation period, in order that staff, who would start their shift after the fall, would know to complete 24 hour post fall observations.

The panel has not been provided with a copy of Resident I's care plan it was informed that there were no notes about the fall within the care plan, nor is there a body map, or incident form. The panel heard evidence from you that you attempted to carry out observations on Resident I in their room following the fall but they refused. However, there is no documentation of this attempt and the refusal of the resident.

The panel considered that while you did not directly observe the fall as the nurse on duty you had the responsibility to ensure that the checks were completed and the documentation filled out, or to have delegated responsibility to the nurse in charge on the next shift.

Therefore, the panel concluded that as there was no documentation of the complete post fall check, which includes making a record of the fall and any observations or attempts to complete observations, it had not been carried out. In light of the panel's findings of your responsibility in this regard the panel found this charge proved in its entirety.

Charge 13a

"In respect of Resident F:

a) Did not administer or offer to administer Resident F's Co-Beneldopa medication at:
i) 14.30
ii) 17.00"

This charge is found proved

The panel considered this charge as a whole as the evidence related to both time periods in question.

The panel heard from Witnesses 2 and 4 in oral evidence who stated that they had reviewed the CCTV footage of the corridor outside Resident F's room for the time periods in question, for an alternative purpose. During their investigation of the footage they noticed that no one had approached Resident F's room to administer their medication at 14.30 or 17.00. The witnesses were consistent in that they had seen you on the CCTV going to the clinical room where medication was stored but that you had not been seen going to Resident F's room. The only person seen going into Resident F's room in between 14:00 and 20:00 was a male staff member with a trolley at around 18:00.

The panel noted that since only one male staff member had been seen approaching the resident's room it was highly unlikely that this was a case of mistaken identity. Further the panel considered there was no uncertainty as to the date and time of the footage given that you were seen on the footage and this was the only day you were working at Acacia. While the panel have not seen the CCTV footage it accepted that two witnesses who have appeared before the panel have viewed it and were both consistent about the content of the footage they observed. The panel have heard no evidence to suggest why these witnesses would provide inaccurate or misleading information. Both witnesses were challenged on if they could have been mistaken and both, independently stated, you were the only person wearing a nursing uniform that day and access to Resident F's room is only by the CCTV covered door. You did not offer an alternative explanation as to how you might have administered the medication at 14.30 or 17.00 but not be seen on the CCTV entering the room. Therefore, the panel accepted the accounts of the CCTV footage provided by Witnesses 2 and 4.

The panel therefore found this charge proved in its entirety.

Charge 14

"Your actions at any or all of Charge 13 b) above were dishonest because

a) You knew that you had not offered Resident F their Co-Beneldopa medication
b) You knew that you had recorded a false account in Resident F's MAR chart
c) You intended to create a misleading impression that Resident F had refused their Co-Beneldopa medication when it had not been offered to them."

This charge is found proved

The panel considered these subcharges together as they relate to the same action of alleged dishonesty.

The panel took into its consideration its conclusions that you had not administered the medication to Resident F. The panel noted the MAR chart which showed your signature against Resident F's medication at the times listed in charge 13b. The panel considered your evidence in respect of Resident F and the fact that you had stated you had made multiple attempts to administer the medication. You stated that at the second time you sought to administer Resident F's medication it was slapped out of your hand and subsequently destroyed. However, the MAR chart entry shows it was only *'refused*' not that you used the code to indicate it was *'refused & destroyed*'. You offered no explanation as to why the witnesses state you were not seen on the CCTV at the relevant times.

The panel considered its conclusions above and the absence of a plausible explanation as to your lack of presence on the CCTV. It considered that you had inaccurately completed the MAR chart in accordance with your evidence and determined that this was due to you in fact not attending upon Resident F.

The panel considered the NMC guidance around dishonesty and found that at the relevant time you did not attend upon Resident F, you knew that you had not offered them the relevant medication, and you created a false account in that regard. The panel considered that an ordinary decent person would consider the act of signing a MAR chart when you knew you had not offered the resident the medication is an inherently dishonest action. This created a misleading impression that Resident F had refused the medication, when it had not been offered.

Therefore the panel found your actions to be dishonest and this charge is found proved in its entirety.

Charge 16

> "Your actions at Charge 15b) above were dishonest because:
>
> a) You knew that you had administered this medication to Resident G on 6 May 2023;
> b) You knew that you had made a false record;
> c) You intended to conceal that you had wrongly administered a second dose of the medication to Resident G on 6 May 2023."

This charge is found not proved

The panel considered these subcharges together as they relate to the same action of alleged dishonesty.

The panel had regard to the statement of Witness 3, the incident form, and the emails to the Agency. In their oral evidence Witness 3 did not state that they thought your actions were dishonest out of an attempt to conceal the medication error but rather that it was a further error in the documentation and record keeping.

The panel considered that in your oral evidence you stated that you were aware of the policy and what should have been done but that you made an error as you were not fully paying attention and misread the MAR chart.

The panel considered the circumstances at the time and the fact that you accepted making a mistake; however, it considered there is no other evidence to suggest this was anything more than a mistake.

The panel considered the NMC guidance around dishonesty and found that you had made a mistake but there was no other evidence to suggest dishonesty. Therefore an ordinary decent person would not have found your actions to be dishonest.

Therefore the panel concluded that while this was an error in record keeping it was not dishonest and this charge is found not proved in its entirety.

Charge 18

> "Your actions at any or all of Charge 17 b) above were dishonest because:
>
> a) You knew that you had not administered the medication
> b) You knew that you had made a false record
> c) You intended to create a misleading impression that Resident H had received their medication."

This charge is found not proved

The panel bore in mind its decision at charge 16 and the close similarities in this charge.

The panel noted that the incident form and the contemporaneous accounts which make no indication that your actions were motivated by dishonesty, but rather that it was an error in record keeping.

The panel heard from you in oral evidence that you did inform the senior staff on the same shift but had made an error in recording the incident.

The panel considered the circumstances at the time and the fact that you accepted making a mistake; however, it considered there is no other evidence to suggest this was anything more than a mistake. The panel has not been presented with any evidence to suggest your actions were dishonest.

The panel considered the NMC guidance around dishonesty and found that you had made a mistake but there was no other evidence to suggest dishonesty. Therefore, an ordinary decent person would not have found your actions to be dishonest.

Therefore, the panel concluded that there was no attempt to conceal what had happened and that this charge is not proved.

Fitness to practise

The panel moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

You gave evidence under affirmation.

Dr Persaud 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.

Dr Persaud identified the specific, relevant standards where your actions amounted to misconduct. These included sections 1.1, 1.2, 8.2, 8.6, 20.1, and 20.2 of the Code. She submitted that your actions breached the fundamental tenets of safe nursing practise and would have been considered deplorable by fellow registered nurses.

Mr Burch submitted on the basis of the panel's findings that you accept that your actions fell below the expected standards of kind, safe, and effective nursing practice and amounted to misconduct.

Submissions on impairment

Dr Persaud moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Dr Persaud submitted all four limbs set out in *Grant* are engaged in this case. She submitted that while there was no direct harm as a result of your misconduct, your actions

placed vulnerable residents at unnecessary risk of harm. She submitted that your actions occurred over a period of some three months, at three different care homes and were not a single isolated incident of misconduct.

Dr Persaud submitted that you have demonstrated limited insight and reflection to the facts found proved and there is therefore a risk of repetition. She submitted that while you have provided some training certificates these are either undated or from 2023, they are not recent examples of strengthening of practice and there is nothing to demonstrate how you would act differently in the future if faced with similar incidents.

Dr Persaud submitted that the dishonesty found proved is highly indicative of attitudinal concerns which are more difficult to remediate, and that you have not provided insight or reflection to the dishonesty. She submitted that you have not reflected on the impact your actions had on the wider nursing profession or the impact on public confidence in nurses.

Dr Persaud submitted that you are currently impaired on both public protection and otherwise in the public interest.

Mr Burch submitted that you are currently not impaired and able to practice kindly, safely, and effectively. He submitted that you have provided a lot of relevant training certificates that demonstrate you have strengthened your practice. He submitted that you have remained in employment as a registered nurse with Omni Healthcare agency since the allegations occurred and there have been no other incidents or concerns about your practice. He submitted that this therefore suggests it is not a deep-seated attitudinal concern.

Mr Burch outlined that there were important contextual factors at the time of the incidents. These included that the incidents occurred on your first or second shift at the care homes, during busy shifts, and in challenging workplaces where you were not a permanent member of staff.

Mr Burch submitted that you have demonstrated remorse for your actions and submitted that your insight into the incidents is developed showing how you would act differently if presented with similar circumstances. He submitted that as you have complied with the interim conditions of practice order imposed upon you and remained working as a registered nurse with no further incidents this demonstrates your strengthened practice and that there is no risk of repetition.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *PSA v NMC and Grant*, *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin), *Cheatle v General Medical Council* [2009] EWHC 645 (Admin) and *Sawati v GMC* [2022] EWHC 283 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. The panel identified the following sections of the Code as areas you breached:

> *'1.1 treat people with kindness, respect and compassion*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> *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*

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

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

The panel also considered that your actions breached sections 1.4, 6.2, 8.2, 8.6, 10.1, 10.2, 10.4, 13.2, 14.3, 20.1, 20.3, and 20.8.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel considered that the facts found proved in charge 8, considered individually do not amount to misconduct. It considered that your actions were influenced by the pre-determined section options that were offered on the 111 Out of Hours service and you therefore had to select the option which most closely resembled the actual situation. The panel considered that while this resulted in you providing inaccurate information it was not a serious misconduct due to the limited options available to you and that you knew you would explain in a phone call the full circumstances.

However, the panel was of the view that your actions at all other proved charges were a significant departure from the standards expected of a registered nurse and would be considered deplorable by fellow practitioners.

The panel found that you engaged in a course of conduct which was persistent and amounted to multiple failures to correctly administer medication and keep appropriate records. The panel noted that it has made several findings of dishonesty involving multiple residents and workplaces in which you intended to conceal your clinical mistakes. The panel determined these acts of dishonesty are significant as they involved taking deliberate risks with the safety of multiple residents. While the panel did not have any

information as to actual harm to residents it considered that your actions could have caused harm.

The panel considered that the facts found proved around dishonesty are especially serious and a significant failure to adhere to the expectations of a registered nurse.

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

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired. In coming to its decision, the panel had regard to the NMC guidance on impairment.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and act with honesty. Patients, and their families must be able to trust nurses with their lives and the lives of their loved ones. Nurses 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,* particularly paragraphs 74 and 76 in reaching its decision.

The panel finds that while there was not actual harm caused to residents there was a serious risk of harm. The panel considered that the medication errors, including not administering or even attempting to administer medication, placed residents at an unnecessary risk of serious harm. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel finds that your actions of not escalating concerns promptly and of being dishonest were a breach of the fundamentals of safe nursing practice. It was satisfied that confidence in the

nursing profession would be undermined if the regulator did not find charges found proved relating to dishonesty extremely serious.

Regarding insight, the panel considered that while you have provided some insight it is limited. You have not fully reflected on the dishonesty element of your actions. The panel considered that your reflection lacks depth and focuses more on the impact your actions have had on you rather than the impact your misconduct had on colleagues, patients, or the wider public. The panel notes that you have not provided any recent reflection using a recognised method, but only submitted reflections from 2023.

The panel considered the advice given on the case of *Sawati* when considering what, if any, effect denials of the charges found proved had on its decision at this stage. The panel considered that you denied secondary facts of dishonesty based on the assessment of primary facts and the denials were not at the unreasonable end of the spectrum, as such the panel did not hold your denials of the charges against you. The panel did, however, assess the other evidence that it had in respect of matters such as insight, including your oral evidence and determined as set out above that you demonstrated a lack of insight.

The panel considered the training certificates you submitted. However, it noted that the only dates were from May 2023 and a significant number were undated, therefore the panel is unable to ascertain what recent relevant training you have completed to strengthen your practice. The panel noted that a number of the training certificates were, as you stated in oral evidence, the mandatory training courses required for employment as a registered nurse and that they were not specific to address the concerns identified. You also made reference to other course that were completed every six months but there was no documentation to support this.

The panel considered that dishonesty is more difficult to remediate. It considered your responses in oral evidence, and the lack of specific reflection on the impact your dishonesty had on colleagues and the risk of harm to patients that arose as a result of your dishonest actions. The panel therefore concluded that there is evidence of an

attitudinal concern and that your insight is very limited. It therefore found there is a risk of repetition of the dishonesty.

The panel considered that while you stated you have remained in employment as a registered nurse it only has testimonials from December 2024. There is no recent information over the last eight months from your mentor, or line manager to speak to your recent practice. In questioning the panel asked what you would do differently if presented with a similar situation: you stated you had experienced a similar situation and acted differently; however, this is not mentioned in your testimonials from employers or colleagues. The panel was therefore not satisfied that you have fully demonstrated sufficient insight into how you have improved your practice to adapt to changes in the future. Therefore, the panel determined that there remains a risk of repetition on the clinical concerns.

In light of all of this, the panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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 determined that a finding of impairment on public interest grounds is required as a reasonable and well-informed member of the public would be concerned if a nurse who had been found to be dishonest and lacking reflection into those actions was not found impaired. The panel considered that your actions may have a detrimental impact on members of the public trusting nurses with the care of themselves, and their loved ones, especially in care homes where the residents may be more vulnerable. The panel considered that given the seriousness of the facts found proved, and the limited insight

and remorse, especially, as regard the impact your actions had on colleagues and the wider public, that a finding of impairment on the grounds of public interest is necessary.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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.

Submissions on sanction

Dr Persaud informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired. She submitted that in light of the panel's findings of misconduct and impairment, given the facts proved, a lesser sanction would not protect the public or uphold the standards expected of a registered nurse. She submitted that given the risk of potential harm to the public and the limited insight demonstrated conditions of practice would not be appropriate in this case and would not protect the public. She submitted that given the attitudinal concerns relating to dishonesty, the fact that your misconduct was a serious breach of the fundamental tenets, and that you failed to practice kindly, safely, and effectively your conduct is incompatible with you remaining on the nursing register.

Mr Burch submitted that you acknowledge the findings on facts, misconduct, and impairment are serious and that you are deeply remorseful for your actions. He submitted

that a striking-off order or a suspension order would be disproportionate in your case; although you acknowledge that an order is necessary in this case. He submitted that a conditions of practice order would be appropriate and that workable conditions can be formulated that would protect the public but allow you the opportunity to continue in practice. He submitted that given the finding that you have limited insight a conditions of practice order would give you the opportunity to develop your insight and further strengthen your practice. He submitted that conditions such as limiting your practice to one employer, having regular meetings with a mentor on the duty of candour, and producing regular written reflections on these meetings would be appropriate and protect the public.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the 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:

- Limited insight into failings
- A pattern of misconduct over a period of time
- Conduct which put vulnerable patients at risk of suffering serious harm

The panel also took into account the following mitigating features:

- Admission to some of the charges, and to misconduct
- Remorse
- Engagement with the substantive hearing

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Although the panel noted that you have been working under an interim conditions of practice order and are willing to comply with a substantive conditions of practice order, it considered that given the seriousness of the misconduct identified there are no workable conditions that would adequately protect the public. The misconduct identified in this case was not something that can be addressed through further training. The panel noted that the findings of dishonesty are attitudinal in nature and not a clinical matter that further training courses may help remediate. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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 conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. The panel found the dishonest conduct was not a one off incident and was deliberate in an attempt to conceal your mistakes. The panel noted you demonstrated remorse and in your oral submissions provided emerging insight into your actions. However, the panel considered the length of time since the allegations have occurred and the lack of current reflection provided to the panel and concluded that on the whole you demonstrated limited insight into the charges including those which you admitted at the outset of the hearing. In light of this lack of insight and taking into account the SG the panel found there is a significant likelihood of repetition and that a suspension order would not adequately address the public protection concerns identified.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was 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.

This will be confirmed to you in writing.

Interim order

As the striking-off 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 interests until the

striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Dr Persaud submitted that an 18-month interim suspension order is necessary on the grounds of public protection and otherwise in the public interest to cover any potential appeal period.

Mr Burch submitted the interim order is a matter for the panel, with no submissions.

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 on the grounds of public protection and otherwise in the public interest to cover any potential appeal period.

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

That concludes this determination.