Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 3 November 2025 -Tuesday 11 November 2025
Thursday 13 November 2025 - Thursday 20 November 2025
Monday 1 December 2025 - Friday 5 December 2025

Virtual Hearing

Name of Registrant:	**Nyembezi Ndlovu**
NMC PIN:	14E0482E
Part(s) of the register:	Registered Nurse - Sub Part 1 RNLD: Learning Disabilities Nurse – level 1 (24 October 2014)
Relevant Location:	Middlesbrough
Type of case:	Misconduct
Panel members:	Anica Alvarez Nishio (Chair, Lay member) Richard Luck (Registrant member) Robin John Barber (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Sara Glen
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter
Ms Ndlovu:	Present and represented by Eleanor Curzon, Counsel instructed by the Royal College of Nursing (RCN)
Facts proved:	Charges 2, 3, & 11d
Facts proven by way of admission:	Charges 11a, 11b
No case to answer:	Charges 12, 13, 14, 17, & 18
Facts not proved:	Charges 1, 4a, 4b, 4c, 4d, 4e, 4f, 5, 6, 7a, 7b, 8, 9a, 9b, 9c, 10a, 10b, 11c, 15a, 15b, 16, 19, 20a, 20b, 21

Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge

‘That you a registered nurse;

1. On 30 October 2022 attended work and/or worked whilst under the influence of alcohol.

2. On 30 October 2022 on one or more occasions failed to administer one or more medications to one or more residents, as set out in Schedule A.

3. On 30 October 2022 on one or more occasions failed to document in one or more residents’ MAR charts that medication/s had been administered, as set out in Schedule A.

4. On or around 23 February 2023 in relation to Resident A;

a. On one or more occasions failed to provide paracetamol to Resident A having been informed by Colleague A that Resident A had requested it.

b. Failed to document in Resident A’s daily notes that Resident A had been requesting pain relief (paracetamol).

c. Failed to document in Resident A’s daily notes that you had administered pain relief to Resident A when it was requested.

d. Failed to score Resident A’s pain and/or document a pain relief score.

e. Failed to order paracetamol and/or laxatives for Resident A.

f. Declared to Colleague A that you had administered paracetamol to Resident A when you had not.

5. Your declaration in charge 4f was dishonest in that you were attempting to mislead Colleague A that you had administered paracetamol to Resident A when you knew that you had not.

6. On or around 23 February 2023 failed to provide medication to Resident E.

7. On 5 March 2023 provided an inadequate handover to Colleague B in that;

a. You could not recall the room numbers of Residents and/or were getting them mixed up.

b. You provided incorrect information about a resident being in room 25 when there was no resident in that room.

8. On 5 March 2023 attended work and/or worked whilst under the influence of alcohol.

9. On or around 8 March 2023, in relation to Resident F;

a. Failed to follow their care plan when instructing staff to provide them with a pureed diet.

b. Failed to make a SALT referral prior to making a decision that they should have a pureed diet.

c. Failed to document and/or update their care plan/medical notes detailing your reasons why they required a pureed diet.

10. On or around 8 March 2023, failed to provide Colleague A Pro-Cal supplements before breakfast for;

a. Resident B.

b. Resident C.

11. On 10 March 2023, in relation to Resident D;

a. Failed to get a second signature for a Butec Patch, a controlled drug.

b. Failed to sign the patch administration charge indicating that the Butec Patch had been applied.

c. Failed to complete and/or sign a body map indicating the location of the applied Butec Patch.

d. On one or more occasions failed to sign and/or check that the Butec Patch was still attached to Resident D once applied.

12. On 10 March 2023, in relation to Resident G;

a. Failed to administer rivaroxaban to them.

b. Documented in Resident G's MAR chart that rivaroxaban had been administered to them when it had not.

13. On or around 10 March 2023, failed to document in Resident H's MAR chart that you had administered/provided Senna medication to them.

14. On or around 11 March 2023 failed to order medication for Resident I.

15. On 14 March 2023;

a. Left medication unattended on the medication trolley.

b. Failed to keep medication locked away and/or secure from access.

16. On one or more occasions, other than that in charge 8, attended work and/or worked whilst under the influence of alcohol.

Whilst employed as a healthcare assistant at August Care Home

17. On 6 September 2023 stated to Colleague A words to the effect of, 'can you speak to Colleague B and ask him to retract his referral to the NMC'.

18. Your declaration in charge 17 lacked integrity as you were seeking that Colleague B withdraw his referral with the NMC for your own benefit; to avoid potential regulatory action being taken against you.

19. On 6 September 2023 physically abused Resident A.

20. On 6 September 2023 documented the following incorrect entries in Resident A's diary for one to one;

a. ‘Top of eyelid red and left side of forehead has a bruise’, not timed.

b. ‘Resident A in the lounge. Bruise on the left side of face under eyelid’, timed at 12.00 – 12.35.

21. Your actions in charge 20a and/or 20b were dishonest in that you were attempting to conceal from others that you had physically abused Resident A.

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

Schedule A:

Resident A

Co-amoxiclav 250mg/125mg tablets:

Morning

Tea

Paracetamol 500mg tablets:

Morning

Lunch

Tea

Sertraline 50mg tablet:

Morning

Adcal-D3 750mg/200unit caplets:

Morning

Alendronic acid 70mg tablets:

Morning

Codeine 15mg tablets:

Morning

Lunch

Tea

Felodipine 2.5mg tablet:

Morning

Memantine 20mg tablets:

Lunch

Resident B

Risperidone 500mg tablets:

Morning

Apixaban 5mg tablet:

Morning

Memantine 20mg tablet:

Morning

Sodium valproate 200mg tablet:

Morning

Spiolto Respimat 2.5micrograms dose:

Two puffs twice daily

Resident C

Paracetamol 500mg tablets:

Lunch

Tea

Gabapentin 300mg capsule:

Tea

Gabapentin 600mg tablet:

Tea

Resident D

Gliclazide 80mg tablet:

Tea

Altrajuce liquid:

Morning

Tea

Carbomer 0.2% eye gel:

Tea

Resident E

Colecalciferol 400unit / Calcium carbonate 1.5g tablet:

Tea

Resident F

Altraplen compact liquid:

Tea

Resident G

Altraplen compact liquid:

Morning

Lunch

Anoro Ellipta 55micrograms / dose / 22micrograms / dose dry powder inhaler:

Morning

Aspirin 75mg tablet:

Morning

Colecalciferol 400unit / Calcium carbonate 1.5g tablet:

Morning

Eplerenone 25mg tablet:

Morning

Fluoxetine 20mg capsule:

Morning

Furosemide 40mg tablets:

Morning

Lunch

Nebivolol 2.5mg tablet:

Morning

Ramipril 1.25mg capsule:

Morning

Resident H

Paracetamol 500mg tablet:

Lunch

Tea

Calcium carbonate 1.25g tablet:

Lunch

Colecalciferol 800unit tablet:

Morning

Haloperidol 500microgram tablet:

Morning

Resident I

Amlodipine 5mg tablet:

Morning

Atorvastatin 10mg tablet:

Morning

Clopidogrel 75mg tablet:

Morning

Resident J

Furosemide 40mg x2 tablets:

Lunch

Resident K

Ferrous fumarate 210mg tablet:

Tea

Mirtazapine 15mg tablet:

Tea

Resident L

Diazepam 1mg:

Lunch

Mirtazapine 15mg:

Lunch

Resident M

Bisoprolol 5mg:

Breakfast

Isosorbide mononitrate 10mg:

Lunch

Tea

Metformin 500mg:

Lunch

Resident N

Fentanyl 12mcg transdermal patch:

Tea

Resident O

Sertraline 100mg:

Breakfast

Thymine 100mg:

Breakfast'

Case Management

Prior to hearing opening submissions, there was a discussion with all parties in relation to the witness running order. The panel were concerned, as was Ms Curzon, on your behalf, that the order of witnesses did not reflect the chronological order of the charges. The charges had been joined and some allegations in later charges rested on former charges. There was concern over the registrant and her representative being able to coherently and therefore fairly cross examine NMC witnesses.

Mr Malik told the panel that he had made attempts prior to the start of this hearing to re-order the witnesses but as some witnesses were deemed to be reluctant and vulnerable he was told that this would not be possible.

The panel accepted the advice of the legal assessor.

The panel considered that there were serious concerns regarding the current order of witnesses and that there is a potential for gross unfairness to you if the current order of witnesses was not amended. The panel noted that the charges were joined at a late stage prior to the commencement of this hearing but given the serious

nature of this case, it determined that efforts should be made to amend the order of witnesses into a chronological order starting with witnesses giving live evidence in respect of the first referral, then in respect of the second referral and finally the third referral.

Application to adjourn the hearing

Ms Curzon made an application to adjourn the hearing for the day and to restart proceedings the next morning. Ms Curzon submitted that this was due to ongoing technical difficulties with your phone and being able to attend the hearing through the Teams application. She submitted that she had spoken to you on multiple occasions throughout the day and that you had expressed your wish to attend the hearing. She submitted that you have engaged with the NMC proceedings thus far and referred the panel to the fact that you had indeed joined proceedings today already but that you were having trouble joining again due to technical difficulties. Ms Curzon told the panel that there were possible measures that could be put in place to help you to attend virtually.

Ms Curzon asked the panel to grant a short adjournment in proceedings to try and resolve the technical issues, and that granting this would be appropriate and proportionate and in the interests of justice in allowing you to be present at a hearing at which you wished to be present.

Mr Malik on behalf of the NMC submitted that he opposed the application for adjournment. He submitted that there is a strong public interest in the expeditious disposal of this case.

Mr Malik submitted that many witnesses have already had to be re-arranged at short notice and that they are typically only warned for that particular day. He submitted that an adjournment to proceedings would be an inconvenience to witnesses and referred the panel to the case of *General Medical Council v Adeogba* [2016] WLR(D) 156. In the interest of overall fairness to all parties and not just to you, he invited the panel to not allow the application to adjourn.

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

Decision and reasons on application for adjournment

The panel had regard to the considerations within Rule 32 of the Rules and to the public interest in the expeditious disposal of these proceedings. The panel noted that any delays may inconvenience the witnesses who have been put on notice to attend the hearing on day one of the proceedings. It considered that you appeared to be making every effort to join proceedings in the afternoon, which you had achieved on the morning. However, it was minded that the difficulties you faced attending virtually appeared to be purely technological. The panel considered that there were possible measures that could be put in place in order to assist your attendance virtually and that it was consequentially proportional to explore the possibility of putting these measures in place. The panel also noted that, while there was strong public interest for the expeditious disposal of the case, a short adjournment would also give time to the NMC to explore the possibility of rearranging the witnesses in a more chronological order and that, on balance would be of fairness to all parties.

Therefore, the panel determined that in the interest of fairness and that you have expressed that you would like to attend the hearing, it would grant the application to adjourn the hearing for a short period in order to try and resolve the technical difficulties that you have faced.

Background

On 30 October 2022, the Nursing and Midwifery Council (NMC) received a referral from Key Healthcare while you were employed as an agency nurse through [PRIVATE] (“Agency One”). Key Healthcare state that whilst on duty at [PRIVATE] (“Home One”) you were suspected of consuming alcohol whilst on shift and a bottle of gin was allegedly found in your bag.

Staff at “Home One” expressed concerns to the Head of Care when you allegedly fell onto a patient’s bed whilst helping another carer to support a patient into bed. The Head of Care, found that you had allegedly not given the medication required at breakfast, lunch and dinner to patients and that you were allegedly swaying, slurring

words and smelt of alcohol when questioned about the incident. You were asked to leave the building and “Agency One” did not give you any further work.

Further charges arose whilst you were employed as a Registered Nurse by [PRIVATE] (“Home Two”). On 22 March 2023, [Home Two] referred you to the NMC stating that there had been several incidents between 23 February 2023 and 10 March 2023 in which issues were raised in relation to your practice. Between the dates 23 and 24 February 2023, [Home Two] alleged that you changed a patient’s diet from modified to pureed without recording any information about your concerns regarding the resident. They alleged that you failed to make a Speech and Language Therapy (SALT) referral in relation to the resident and changes in their dietary needs. Between the dates 1 and 16 March 2023, [Home Two] alleged that there were multiple incidences where you failed to administer medication, sign for medication and failed to get a second signature for a controlled drug. There were also concerns that you had attended work under the influence and had alcohol in your bag. As a result of the alleged incidences, you did not pass your probationary period at [Home Two] and consequently left on 22 March 2023.

Additionally, you self-referred on 12 September 2023 after being questioned by Darlington Police. Subsequently, another referral was received by the NMC on 15 September 2023 from [PRIVATE] (“Agency Two”) who alleged that on 6 September 2023, whilst you were working at [PRIVATE] (“Home Three”) there was a safeguarding incident raised as a result of a resident sustaining unexplained bruising to their face. Agency Two stated that the resident, who has dementia, allegedly sustained the injuries during a 1:1 with you. The police were involved and you were suspended. The police investigation was closed with no further action taken.

Decision and reasons on application to admit the hearsay evidence of Witness 9 and Witness 10.

The panel heard an application made by Mr Malik under Rule 31 to allow the written statement of Witness 9 dated 13 February 2025, Exhibit KB01 and Exhibit KB02 into evidence. He also made an application under Rule 31 to allow the written statement of Witness 10 dated 4 December 2023 and Exhibit RF01 into evidence.

He submitted that Rule 31 allows for hearsay evidence to be admitted, and it is *prima facie* admissible, if it is relevant and fair. Mr Malik referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 and to the factors as set out in paragraph 56:

> '*1. 'Whether the statements were the sole and decisive evidence in support of the charges;*
> *2. The nature and extent of the challenge to the contents of the statements;*
> *3. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> *4. The seriousness of the charge, taking into account the impact which adverse findings might have on N's career;*
> *5. Whether there was a good reason for the non-attendance of the witnesses;*
> *6. Whether the Respondent had taken reasonable steps to secure the attendance of the witness;*
> *7. The fact that N did not have prior notice that the witness statements were to be read.'*

Mr Malik submitted that in respect of Witness 9, her evidence is not the sole and decisive evidence in respect of Charges 1 and 2. He submitted that Witness 2's evidence also corroborates Charges 1 and 2 and that they will be giving live evidence at this hearing and that their evidence be afforded the opportunity to be cross examined and tested. He further submitted that Witness 11's written statement and exhibits further corroborate Witness 9's evidence in respect of Charges 1 and 2.

He submitted that there is no reason to suggest that Witness 9 has fabricated her evidence and that they are a professional. He submitted that there is no reason for them to lie about their evidence, their NMC statement is signed, dated and accompanied by a statement of truth and their local statement is also signed and dated.

During the process of hearing submissions on the admission of hearsay evidence, Mr Malik made an application for part of his submissions to be heard in private. He informed the panel that there will be reference to matters relating to Witness 9's

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

Ms Curzon did not oppose this application.

The panel accepted the advice of the legal assessor.

The panel determined that matters relating to Witness 9's health should be heard in private as and when they may be referenced to protect Witness 9's privacy.

Mr Malik submitted that the charges in this case are serious and that there is a good reason for the non-attendance of Witness 9 at this hearing. He submitted that Witness 9 had provided a [PRIVATE]. He submitted that the NMC has taken reasonable steps to secure their attendance including numerous telephone attempts and a witness summons.

Mr Malik submitted that you were made aware that Witness 9 would not be in attendance and that the NMC would be relying on their witness statement. He submitted that Witness 9's statement and Exhibit KB01 and KB02 is clearly relevant and that it would be fair to admit into evidence as hearsay in these circumstances.

In respect of Witness 10, Mr Malik submitted that their evidence is sole and decisive in relation to Charges 12, 13 and 14 and that this is supported by their NMC statement dated 4 December 2023 and their local statement contained in Exhibit RF01.

He submitted that Witness 10 is a professional and that there is no reason to suggest that Witness 10 had fabricated their evidence in any way. He submitted that their NMC statement is signed, dated and accompanied by a statement of truth. He further submitted that the NMC has taken reasonable steps to secure their attendance.

Mr Malik submitted that you were made aware that Witness 10 would not be in attendance and that the NMC would be relying on their witness statement. He

submitted that Witness 10's statement and Exhibit RF01 is clearly relevant and that it would be fair to admit into evidence as hearsay in these circumstances.

Ms Curzon, on your behalf submitted that she opposed the application for Witness 9 and Witness 10's evidence to be admitted as hearsay evidence.

She referred the panel to the case law of *R (on the application of Bonhoeffer) v General Medical Council* [2011] EWHC 1585 (Admin), *Thorneycroft*, *Ogbonna v Nursing and Midwifery Council* [2010] EWCA Civ 1216, *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin) and *McEwan* v *DPP* [2007] EWHC 740 (Admin).

In respect of Witness 9, she submitted that their evidence is decisive in regard to Charges 1, 2, and 3. She submitted that it would be unfair to you to allow the admission of Witness 9's evidence as hearsay and that there are a number of questions regarding inconsistencies in Witness 9's evidence, which also does not feature in statements from other Witnesses, that you would not be able to test due to their non-attendance. Ms Curzon submitted that you are facing grave, serious allegations and if found proved would have a devastating impact on your career, [PRIVATE] and on your reputation. Further Ms Curzon submitted that an essential part of the panel's assessment of credibility is to consider a witness's demeanour whilst giving evidence. She submitted that due to Witness 9's non-attendance, this would not be able to take place.

Ms Curzon submitted that there is no good reason for Witness 9's non-attendance. She submitted that Witness 9's non-attendance is due to [PRIVATE]. She submitted that [PRIVATE]. She submitted that this does not mean that [PRIVATE] and that adaptations are made regularly at NMC proceedings [PRIVATE]. Therefore, in all circumstances, Ms Curzon submitted that under Rule 31, it would not be fair to admit Witness 9's evidence as hearsay.

In respect of Witness 10, Ms Curzon submitted that their evidence is the sole evidence in respect of Charges 10b, 12, 13, 14 and is the decisive evidence in respect of Charge 4e. She submitted that their evidence directly relates to the issues

in dispute and that you would not have the opportunity to challenge their evidence or enquire of their sources as a result of their non-attendance at this hearing.

She submitted that there is no good reason for Witness 10's non-attendance at this hearing and that they appear to have purposefully absented themselves. She submitted that their reasoning that they have a new job and [PRIVATE] the NMC is insufficient to allow them to attend this hearing is not a good enough reason. She submitted that the NMC did not seek a witness summons in respect of Witness 10. Further she submitted that Witness 10 appeared to have disengaged entirely, and that Witness 10 was unlikely to attend on any future date.

She submitted that there is a public interest in the expeditious disposal of the case and that it would be unfair and prejudicial to adduce Witness 10's evidence as hearsay. She invited the panel to refuse the application to admit Witness 10's evidence as hearsay in respect of the seriousness of the allegations against you.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. It also included reference to NMC guidance DMA-6 namely '*Evidence*' last updated 9 June 2025.

In respect of the application to allow Witness 9's evidence to be admitted as hearsay, the panel determined that given the seriousness of the allegations against you and the overarching objective to protect the public, it would be fair and appropriate to hear all facts of this case before ruling on whether or not to admit Witness 9's evidence as hearsay.

In respect of the application to allow Witness 10's evidence to be admitted as hearsay, the panel was of the view that Witness 10's evidence is the sole and decisive evidence in respect of Charges 12,13 and 14. It considered that the allegations against you are serious that and that it would be unfair and prejudicial for you to not have the opportunity to test Witness 10's evidence. The panel considered

that Witness 10 appeared to be purposefully absenting themselves from proceedings and that there was no good reason for their non-attendance at this hearing. The panel also noted that Witness 10 appeared to be no longer a registrant themselves due to Fitness to Practice proceedings in relation to them and that in their reluctance to attend this hearing, this impacted their credibility as a witness. In these circumstances, the panel refused the application to admit Witness 10's evidence as hearsay.

After hearing all live evidence from the NMC witnesses, and in respect of the application to allow Witness 9's evidence to be admitted as hearsay, the panel determined that Witness 9's evidence was not sole and decisive. It determined that Witness 9 was a credible witness as she was working in a senior position at the time of the alleged incident and there has been no indication of any issues with you. Therefore, it considered that there was not a reason for Witness 9 to fabricate their evidence. The panel determined that in light of Witness 9's nonattendance at this hearing and in not having the opportunity to test her evidence, it would have the ability to consider it with all of the evidence presented at this hearing and attribute the appropriate weight according to the balance of probabilities at the fact-finding stage of this hearing. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

Therefore, the panel accepted the application to admit Witness 9's evidence as hearsay. In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Witness 9 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit the hearsay evidence of Witness 8

The panel heard an application made by Mr Malik under Rule 31 to allow the written statement of Witness 8 dated 11 March 2024 into evidence. He submitted that Rule 31 allows for hearsay evidence to be admitted, and it is *prima facie* admissible, if it is relevant and fair. Mr Malik referred the panel to the case of *Thorneycroft* and to the

factors as set out in paragraph 56.

Mr Malik submitted that in respect of Witness 8, her evidence is not the sole and decisive evidence in respect of Charges 17 and 18. He submitted that the panel heard live evidence from Witness 6 who stated that although they were not a direct witness to the alleged incident, she was aware of it and states that she knew that it occurred on 6 September 2025. He further submitted that in her live evidence, Witness 6 told the panel that Witness 8 came to her office to raise a concern. Mr Malik submitted that this account corroborates Witness 8's evidence.

Mr Malik submitted that there is no evidence before the panel to suggest that Witness 8 has any reason to fabricate her evidence. He submitted that her relationship with you was on a strictly professional basis and therefore she had no reason to lie about what you allegedly asked her to do. He further submitted that Witness 8's NMC statement is signed, dated and accompanied by a statement of truth.

Mr Malik submitted that the charges in this case are serious and that there is a good reason for the non-attendance of Witness 8 at this hearing. Mr Malik submitted that Witness 8 was originally warned to give her evidence at this hearing on Monday 3 November 2025. He submitted that her date for giving her evidence was moved toward the end of the week as a result of the panel's decision to hear the evidence of this case in order of referral. He submitted that the panel was provided with email correspondence from Witness 8 to the NMC Hearing coordinator dated 6 November 2025 stating that she would be unable to attend due to concerns regarding her health. He submitted that the NMC has made several attempts to try and secure her attendance at this hearing but this situation is something that one could not foresee.

Therefore, Mr Malik submitted Witness 8's statement is clearly relevant and that it would be fair to admit into evidence as hearsay in these circumstances.

Ms Curzon, on your behalf submitted that she opposed the application for Witness 8's evidence to be admitted as hearsay evidence. She referred the panel to the

principles of *Thorneycroft* and submitted that it would be unfair to you and prejudicial if Witness 8's evidence was admitted as hearsay.

Ms Curzon submitted that Witness 8's evidence is sole and decisive in respect of Charges 17 and 18. She submitted that Witness 8 is the sole individual who is able to recount the conversation that she is alleged to have had with you. She submitted that the entirety of that conversation is disputed such that it is your position that the conversation never took place at all. Ms Curzon further submitted that in respect of Witness 8's evidence there is a challenge to Witness 8's credibility as she states that she was aware of a previous referral in her written statement.

Ms Curzon further submitted that Witness 8's non-attendance at this hearing deprives you of the opportunity to test her evidence. She submitted that in respect of the grave and serious allegation against you regarding your integrity, the panel should take this factor into consideration and that any adverse finding in respect of Charges 17 and 18 would have a significant impact on your career as a Registered Nurse.

Ms Curzon submitted that there is no good reason for Witness 8's non-attendance at this hearing and that the email dated 6 November 2025 is insufficient. She stated that there is no supporting documentation such [PRIVATE] and that we do not know Witness 8's current situation regarding [PRIVATE]. She submitted that reasonable adjustments could have been made to support Witness 8 to attend to give her evidence, especially in light of the fact that this is a virtual hearing and thus travel is not required. She submitted that a witness summons would not resolve this issue.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

In respect of the application to allow Witness 8's evidence to be admitted as hearsay, the panel was of the view that Charges 17 and 18 are of a serious nature

and Witness 8's evidence was the sole and decisive evidence for these charges. The panel considered that there has been no further evidence such as [PRIVATE] or [PRIVATE] put before it to verify the information provided by Witness 8 in the email dated 6 November 2025 detailing why she would not be able to attend to give her evidence, and that it was a virtual hearing, which negated any burden which travelling might have placed on the witness.

Regarding the seriousness of the allegations against you in respect of Charges 17 and 18, the panel also considered that as a result of Witness 8's non-attendance at this hearing you will not have the opportunity to challenge these allegations. Further, the panel noted that in Witness 8's NMC statement dated 11 March 2024, she states that she was aware of a previous alleged incident concerning you, and that due to her non-attendance at this hearing you would not be afforded the opportunity to challenge this allegation either.

In these circumstances the panel refused the application to allow Witness 8's evidence to be admitted as hearsay.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Curzon on your behalf that there is no case to answer in respect of Charges 4e, 12, 13, 14, 17, 18. This application was made under Rule 24(7).

Ms Curzon referred the panel to the case law of *R v Galbraith* (1981) 73 Cr. App. R. 124, and *R. (on the application of Tutin) v General Medical Council* [2008] EWHC 553.

In relation to Charge 4e, Ms Curzon submitted that there is no evidence to support the allegation that you failed to order paracetamol and/or laxatives for Resident A. She submitted that that panel have heard no evidence at this hearing that you were required to order either of these medications or that you were asked to do so. She submitted that the panel heard from Witness 5, who in her oral evidence stated that

Resident A's wife would bring paracetamol into the unit in her handbag for Resident A, however there was no mention of your alleged failure to order paracetamol and/or laxatives for Resident A specifically. She submitted that if the panel were minded to find that there was some evidence to support Charge 4e, then it is of such a tenuous and unsatisfactory nature that a panel, properly directed, could not find the matter proved.

In regard to Charges 12, 13 and 14, Ms Curzon submitted that there is no evidence to support these charges. She submitted that the sole witness who speaks to these charges is Witness 10 and that they have not attended this hearing. Further an application to admit Witness 10's evidence as hearsay was made by the NMC and was not upheld. She submitted that as Witness 10's evidence is the only evidence sought to be relied upon in respect of Charge 12, 13 and 14, and as a result of his evidence being found to be inadmissible, there is therefore no evidence in which to support the charges and therefore they cannot be proved.

In regard to Charges 17 and 18, Ms Curzon submitted that the evidence before the panel is of such a vague and inherently tenuous nature that a panel, properly directed, could not find the charges proved. She submitted that the relevant, direct witness for these charges is Witness 8. She submitted that Witness 8 has not attended this hearing to give her evidence and that an application by the NMC for her evidence to be admitted as hearsay was not upheld. Therefore, Ms Curzon submitted that Witness 8's evidence is inadmissible.

Ms Curzon submitted that there is no direct evidence to support the allegation that you used words to the effect of those set out in Charge 17. She submitted that the only evidence that the panel heard in respect of this issue was from Witness 6. She submitted that when Witness 6 was questioned while giving her oral evidence she stated that you had "*asked [Witness 8] to speak to her operations manager and asked to retract a statement he had made previously*." Ms Curzon submitted that this is not the same as what is alleged in Charge 17 as it is specific to a referral to the NMC.

She submitted that during cross examination, Witness 6 confirmed that she had not been privy to the conversation between you and Witness 8, but she had been informed of this conversation by Witness 8 which renders her evidence as hearsay.

Therefore, Ms Curzon submitted that there is no direct evidence of the words of Charge 17 being used by you at all. She submitted that the evidence before the panel in respect of these charges is inherently vague and insufficient to be able to find the charge proved. Consequently, Ms Curzon submitted that Charge 18 is also not able to be found proved as it is reliant on Charge 17 being found proved.

In these circumstances, it was submitted that Charges 4e, 12, 13, 14, 17, and 18 should not be allowed to remain before the panel.

Mr Malik referred the panel to the case law of *Galbraith* and the NMC guidance DMA-6 namely '*Evidence*' last updated 9 June 2025.

In regard to Charges 12 ,13 and 14, Mr Malik submitted that these charges fall under the first limb of *Galbraith*. He acknowledged that there is no evidence to support these charges. He acknowledged that Witness 10's evidence was sole and decisive in respect of the charges. He submitted that the NMC does not have the MAR charts in their possession despite attempts to obtain them from Home Two.

Mr Malik submitted that there is a case to answer in respect of Charges 4e, 17 and 18.

He submitted that Charges 4e, 17 and 18 fall under the second limb of *Galbraith* and that the witnesses in this hearing have given credible, reliable and consistent evidence.

In regard to Charge 4e, Mr Malik submitted that in her live evidence Witness 1 was clear, concise and consistent with what she said and that the panel can rely upon this. He submitted in her NMC statement dated 18 December 2023, she stated:

'*The registrant was also meant to order more paracetamol for Resident A from [PRIVATE] as well as laxatives but she failed to do this'*

He submitted that there was no reason for Witness 1 to lie or fabricate her evidence. Mr Malik referred the panel to a letter dated 16 March 2023 from Home One to you. This letter informed you that you had failed your probationary period due to raised concerns and stated:

'*You then informed us that as part of a DST meeting 10 March 2023 relating to this resident that you were requested to order paracetamol and on reviewing the medication records this still had no been completed, you advised that you hadn't recorded this on fusion but recorded this within your own notes but no one had access to this*.'

Mr Malik submitted that this letter clearly shows that you accepted that you were requested to order paracetamol for Resident A and that records were checked and found to be incomplete. He submitted that as a Registered Nurse, you should be aware of the importance of record keeping.

Mr Malik submitted that Witness 1 does not demonstrate inherent weakness in her evidence and that her evidence can be relied upon. He submitted that taken at its highest, her evidence is capable of being found proved.

In relation to Charges 17 and 18, Mr Malik submitted that Witness 8 is a direct witness. He submitted that in her NMC statement dated 14 February 2024, Witness 6 said:

'Regarding the incident when the registrant asked a member of staff to retract some information, I didn't witness this, but I know that it happened on the 6 September 2023 after the registrant had spoken with me about picking up some extra shifts.'

Mr Malik submitted that it has been raised during this hearing that Witness 6 is not a direct witness, but he submitted that she was consistent in her oral evidence and that she accepted that although she was not present at the time of the conversation between you and Witness 8, she was aware that it took place. Mr Malik reminded the panel that Witness 6, in her oral evidence said she was aware of the conversation because Witness 8 came to her office and told her about it. He submitted that this corroborates what Witness 8 said in her documentary evidence.

Mr Malik submitted that Witness 6 does not demonstrate an inherent weakness in her evidence and taken at its highest Charge 17 is capable of being found proved.

In regard to Charge 18, Mr Malik submitted that it is a matter for the panel to decide as it is reliant upon Charge 17 being found proved.

In conclusion, Mr Malik submitted that there is a case to answer in respect of Charges 4e, 17 and 18.

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

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

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 Charges 17 and 18 proved. The panel determined that Witness 8's evidence was inadmissible. The panel heard oral evidence from Witness 6 at this hearing, who stated that she did not witness the conversation between Witness 8 and you but that she knew it happened on 6 September 2023. The panel determined that her oral evidence is inconsistent with what is outlined in Charge 17 with nothing being mentioned about the NMC at all. The panel determined that the evidence relating to Charge 17 is too vague and

tenuous and could not find it proved. The panel determined that as Charge 17 could not be found proved, then Charge 18 could not be found proven either.

In regard to charge 4e, the panel was of the view that there had been sufficient evidence to support the charge 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 determined that Witness 1 was a senior manager and as such, would be fully aware of the processes and systems in Home One. Further the panel considered the letter dated 16 March 2023 which implies that you accept some degree of responsibility to order medication. The panel determined that there is sufficient evidence to review in relation to Charge 4e and what weight it gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel noted that Mr Malik acknowledged that there was no case to answer in respect of Charges 12,13,14.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Curzon, who informed the panel that you made full admissions to Charges 11a and 11b.

The panel therefore finds Charges 11a and 11b proved in their entirety, by way of your admissions.

The panel also had regard to its earlier decision where it determined that there was no case to answer in respect of Charges 12, 13, 14, 17 and 18.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Malik on behalf of the NMC and by Ms Curzon on your behalf.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This

means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

In addition, the panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Clinical lead at Home One.
- Witness 2: The Area Manager for Home One at the time of the incident.
- Witness 3: Currently employed at Home One as a Care Assistant. Was a Senior Care Assistant at Home One at the time of the incident.
- Witness 4: Currently employed as a Care Home Associate Practitioner at Home Two. Employed in this role at the time of the incident.
- Witness 5: Currently employed at Home Two as a Care Assistant. Was employed in this role at the time of the incident.
- Witness 6: Currently employed by Home Three as the Home Manager. Was working in this role at the time of the incident.

- Witness 7: Employed by Home Three as a Registered Nurse at the time of the incident.
- Witness 8: Employee of Home Two as the Quality Manager at the time of the incident
- Witness 9: Employee of Key Healthcare as the Head of Care of the residential unit at Home One at the time of the incident.
- Witness 10: Employed as a Registered Nurse at Home Two at the time of the incident.
- Witness 11: Currently employed at Home Three as the Home manager.

The panel also heard evidence from you under oath.

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

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

Charge 1

‘That you a registered nurse;

1. On 30 October 2022 attended work and/or worked whilst under the influence of alcohol.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 3, the documentary hearsay evidence of Witness 9, the DNA Workplace Report dated 18 April 2024, your [PRIVATE] dated 24 January 2023 and your oral evidence.

The panel considered Witness 3's local statement dated 30 October 2022 in which he said, '*I could smell alcohol on her, her clothes seemed to smell of it*' and his NMC witness statement dated 24 October 2025 in which Witness 3 said:

> '*The registrant seemed tipsy and when you went close to her, you could smell alcohol off her*.'

Further, in his oral evidence, Witness 3 told the panel that your breath smelt of alcohol and that you had been swaying from side to side.

The panel also considered the documentary evidence of Witness 9, who in her local statement dated 31 October 2022 stated that a member of staff from Home One had called her with a concern that you had been drinking alcohol and that the member of staff had seen a bottle of gin in your open bag. Witness 9 said that she asked the staff member to take a photo of the open bag if the bottle was easily seen. Upon arrival at Home One, Witness 9 said:

> *'I noted the agency nurse was swaying and slurring her words. I said she smelt of drink.*'

Further, the panel considered the NMC witness statement of Witness 9 dated 13 February 2025 in which she said:

> '*I went into the office, that's where her bag was and that's when I saw the alcohol. Her bag was open, and there was a bottle of gin, it was quite visible…I took the photo of the gin in the agency nurse's bag. I took the photo on my phone and passed it on to the home*.'

In your oral evidence, you told the panel that you do not use alcohol except in religious ceremonies/ceremonial purposes in your home country of Zimbabwe and only used alcohol on these occasions. Further, you told the panel that you would apply hand sanitiser not only to your hands but also to your tabard that you were wearing as Covid was very recent, there was Long Covid in Home One in 2022 and some of the residents were vulnerable. You also told the panel that you did not want to bring anything back home with you. You told the panel that you used your own hand sanitiser which you brought with you and that the hand sanitiser had '*quite a strong smell'.* Further, you told panel that the bag in the photograph exhibited by Witness 9 was not your bag and was a different size and type to your bag.

Further in answer to the allegation that you were slurring your words and swaying; you told the panel that you had concerns with [PRIVATE] since the beginning of 2021 [PRIVATE].

The panel determined that there was no corroborating evidence to support the allegation that on 30 October 2022 you worked under the influence of alcohol. The panel noted that there were inconsistencies in Witness 9's accounts in her local statement and NMC witness statement as to who took the photograph. In one account Witness 9 states that she asked a staff member to take the photograph, in another account Witness 9 said that they took the photograph themselves. The panel further noted that there has been no corroborating evidence to indicate that you were in fact drinking alcohol whilst you were on shift. The panel took account of the timing of the incidents. It noted that Covid was still rife in the community at this time, that there was a higher prevalence of Covid in ethnic communities within the UK and that you worked within care homes which were also disproportionately negatively affected by Covid, and determined that your oral evidence about the amount and manner of hand sanitiser was credible. The panel considered your oral evidence

regarding [PRIVATE] to be consistent and that your version of events is entirely plausible set against the hearsay evidence of Witness 9.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 2

‘That you a registered nurse;

2. On 30 October 2022 on one or more occasions failed to administer one or more medications to one or more residents, as set out in Schedule A.’

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 2, the documentary and oral evidence of Witness 3, the documentary hearsay evidence of Witness 9 and your documentary and oral evidence.

In her NMC witness statement dated 13 February 2025 Witness 9 said:

> *‘…I went downstairs to the treatment room/medical room. I got the folder with the MAR charts in, to see if anything had been signed for teatime medication round, nothing had been signed for. I checked the medi pots and all the medication was still there for everyone. I only checked spring unit. I didn’t go to summer unit. In the treatment room/medical room I found medication from breakfast, lunch and teatime not given.’*

In his NMC witness statement dated 24 October 2025, Witness 3 said:

‘The registrant didn’t administer medication on the day of the incident to the residents because the residents were asked and they said confirmed (sic) of not receiving anything.’

In his oral evidence, Witness 3 told the panel that he had asked the residents if they had received their medication and some of the residents told him that they had not. When asked by the panel if you could have given the medication but not yet written it on the MAR charts, Witness 3 said “*it could be… sometimes notes can be taken and then MAR charts later transcribed.”* During panel questions, Witness 3 told the panel that he also did not think the medicine had been given as he could not see any medicine pots in the bin.

In her NMC witness statement dated 13 February 2025, Witness 9 stated that Home One was suffering from staffing issues. She said:

‘*The home was suffering from staffing issues. Two senior care assistants had resigned with immediate effect on 28 October 2022. There were issues with care plans, that’s why there was an embargo on Four Seasons Care Centre from the CQC. It was a tough time. We weren’t allowed to accept any new patients.’*

In her oral evidence, Witness 2 confirmed that Home One was subject to staffing issues as when asked by the panel whether there would be one nurse in one unit, and one nurse in the other unit, Witness 2 said, “ *due to shortness of staff… a senior care assistant or nurse would have to do both units*.”

In your oral evidence, you told the panel that on the date in question, it was your second shift working at Home One and that you had to look after two areas, ‘*Spring*’ ward and ‘*Summer*’ ward which were across a car park from each other. The panel saw photographic evidence that this was the case. You told the panel that both wards had approximately fifteen to twenty residents.

You were candid in your oral evidence when you told the panel that you were running late when giving breakfast, lunch and dinner medications due to being

unable to administer some medication to residents as they were asleep or refusing to take the medication. You also told the panel that you were called away to assist with residents' buzzers and care staff whilst in the middle of your medication round. You told the panel this had a knock-on effect throughout the day as it took you three hours to complete the breakfast medication round in both units and you then had to return to try and give medication to those that were missed. You told the panel that the lunchtime medication round began at 12:00 and that you were still trying to catch up on breakfast medications when the lunchtime medications were due. You told the panel the same occurred again at teatime and that you were asked to leave the premises before you could complete that medication round and write up the MAR charts using your piece of paper. You said in your written statement, '*I confirm that teatime medications were not completed because I was instructed to hand over the keys and leave the premises.*' You told the panel that you provided the piece of paper to Witness 9 when you left but you do not know what happened to it after that.

When asked during panel questions if you thought it was appropriate to write down who you were or were not giving medication to, and then filling in the MAR chart later on in the day, you told the panel that you thought that it was not appropriate but that it worked for you and Witness 3 the day before when you were doing the medication round together and so you adopted that strategy on this day as well. When asked if you thought it was good practice, you told the panel "*I wouldn't say so, no.*"

The panel heard evidence that you were working in a challenging and complex environment. The panel heard that the location of the two units you were working in were situated across a car park from each other and that you were required to carry out medication administration in both wards. The panel heard evidence that patients in both wards were of varying capacity. As a result, the panel determined that they could not rely on Witness 3's evidence stating that he had asked residents if they had received medication, many said they had not, the panel were unable to ascertain if this was the truth as it heard that many residents had varying capacity.

Taking all evidence into account, whilst the panel accepted there was a credible explanation for your failure the panel determined on a balance of probabilities that you did fail to administer medication and therefore found this charge proved.

Charge 3

‘That you a registered nurse;

3. On 30 October 2022 on one or more occasions failed to document in one or more residents’ MAR charts that medication/s had been administered, as set out in Schedule A.’

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 2, the documentary and oral evidence of Witness 3, the documentary hearsay evidence of Witness 9 and your oral evidence.

In her oral evidence, Witness 2 confirmed that Home One was subject to staffing issues as when asked by the panel whether there would be one nurse in one unit, and one nurse in the other unit, Witness 2 said, “*due to shortness of staff… a senior care assistant or nurse would have to do both units*.”

In her NMC witness statement dated 13 February 2025 Witness 9 said:

> *‘…I went downstairs to the treatment room/medical room. I got the folder with the MAR charts in, to see if anything had been signed for teatime medication round, nothing had been signed for. I checked the medi pots and all the medication was still there for everyone. I only checked spring unit. I didn’t go to summer unit. In the treatment room/medical room I found medication from breakfast, lunch and teatime not given.’*

In his NMC witness statement dated 24 October 2025, Witness 3 said:

> *‘The registrant didn’t administer medication on the day of the incident to the residents because the residents were asked and they said confirmed (sic) of not receiving anything.’*

In your written statement dated 29 October 2025, you said:

> '*[Witness 3] and I kept notes on a piece of paper with details of administered medications and intended to transcribe these onto the medication administration record (MAR) charts at the end of the shift… The shift was further complicated by the fact that a staff member scheduled for the evening called in sick and I had requested permission to stay late to complete the shift but was informed there was a "no overtime" policy… . I did my best to ensure all medications were administered appropriately and documented as far as possible given the staffing and procedural issues present… . However, before I could complete the documentation, I was instructed to leave the premises because of the alcohol allegation. I handed the written notes to [Witness 9] who declined to review them. These notes contained the information required to update the MAR charts*.'

You confirmed this in your oral evidence. When asked during panel questions if you thought it was appropriate to write down who you were or were not giving medication to, and then filling in the MAR chart later on in the day, you told the panel that you thought that it was not appropriate but that it worked for you and Witness 3 the day before when you were doing the medication round together. You told the panel that you adopted the same strategy on this day as well. When asked if you thought it was good practice, you told the panel "*I wouldn't say so, no.*"

The panel considered that as a Registered Nurse, it was part of your duty to ensure that the MAR chart had been appropriately filled out. The panel noted your acknowledgement in your oral evidence that you adopted "*a different strategy"* in that you said you were noting who you had given medication to, and who had not received medication on a piece of paper.

The panel had sight of the MAR charts and noted that there were many with missing signatures for medication administration. The panel acknowledged that you appeared to be working in challenging circumstances but your admission in your oral evidence that what you were doing was not good practice and the many missing

signatures on the MAR charts and your missing piece of paper mean that it is not known who received their medication. The panel considered as a Registered Nurse it is part of your responsibility to ensure that records are kept up to date as contemporaneously as possible.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 4a

'That you a registered nurse;

4. On or around 23 February 2023 in relation to Resident A;

    a. On one or more occasions failed to provide paracetamol to Resident A having been informed by Colleague A that Resident A had requested it.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 5, the documentary and oral evidence of Witness 1, the daily notes of Resident A dated between 23 February 2023 and 24 February 2023 and your documentary and oral evidence.

In her local statement dated 30 January 2024, Witness 5 said that Resident A had asked her for some paracetamol and that she asked you to give the paracetamol to Resident A. She said:

> '…*about 30 minutes later Resident A pressed his call button I went to see him and he had asked where his paracetamol were I said I would find out I asked nurse [PRIVATE] and she said she was going to give them to him about another 30 minutes Resident A came out asking for his paracetamol again I went and seen nurse Bezzie She said she had given them to Resident A so I told Resident A he had been given them to which he said he hadn't had them*.' (sic)

Witness 5 confirmed this version of events during her oral evidence at this hearing.

In her NMC witness statement, Witness 1 said:

> '*The registrant should have gone and given him the paracetamol, which was prescribed to him for pain relief. She should have asked where the pain was and scored his pain and given him the paracetamol as a first option and then evaluated the effectiveness and given something strong (sic) if needed.'*

In your oral evidence, you told the panel that you could not specifically recall any conversation with Witness 5 regarding Resident A and paracetamol due to the passage of time however you said that if anyone asked you to provide any paid relief, you would always assess their pain level first and if pain relief was required then you would administer as appropriate. You also explained to the panel the difference between regular medication and pro re nata (PRN/ '*when necessary or as required'*) medication. You told the panel that if paracetamol was included in a resident's regular medications you would document it as '*accepted medications'*, but if a resident had PRN medication such as paracetamol, you would document that separately to say they have received that medication. In your written statement dated 29 October 2025 you said:

> *'No concerns were raised with me at the time regarding an alleged failure to provide prescribed pain relief. I would not have knowingly failed to respond to a resident's pain needs.'*

The panel had sight of the daily notes of Resident A dated 24 October 2023 in which you documented '*accepted medications.'* The panel were not afforded the sight of Resident A's MAR chart at this hearing and therefore were unable to ascertain if Resident A was receiving regular paracetamol as part of their medications or if they were having paracetamol PRN. The panel determined that there was not enough direct or cogent evidence to determine that you failed to provide Resident A with paracetamol having been informed by Colleague A on one or more occasions.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 4b

‘That you a registered nurse;

4.On or around 23 February 2023 in relation to Resident A;

b. Failed to document in Resident A’s daily notes that Resident A had been requesting pain relief (paracetamol).

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 5, the documentary and oral evidence of Witness 1, the daily notes of Resident A dated between 23 February 2023 and 24 February 2023 and your documentary and oral evidence.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 5, the documentary and oral evidence of Witness 1, the daily notes of Resident A dated between 23 February 2023 and 24 February 2023 and your documentary and oral evidence.

In her documentary and oral evidence Witness 5 said that Resident A asked her for some pain relief. Witness 5 told the panel that she passed this request to you. She then told the panel that Resident A came back to her sometime later stating that they had never received their requested pain relief.

In your oral evidence, you told the panel in respect of the administration of medication you would only record the giving of paracetamol to Resident A in their MAR chart if were having it PRN. Otherwise, you told the panel you would just write ‘*medication accepted’* in the daily notes. You told the panel that if you were asked to provide paracetamol then you would have given it.

The panel noted that no MAR chart was provided for Resident A for this charge. It further noted that you wrote in the daily notes of Resident A on 24 February 2023 '*accepted medications.*' The panel determined that without having sight of Resident A's MAR chart for the date in question, it could not confirm if Resident A was the recipient of regular prescribed paracetamol or paracetamol on a PRN basis. As such, the panel determined that there was not any direct evidence to suggest that you failed to document in Resident A's daily notes that they requested pain relief. Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 4c

'That you a registered nurse;

4.On or around 23 February 2023 in relation to Resident A;

c. Failed to document in Resident A's daily notes that you had administered pain relief to Resident A when it was requested.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 5, the documentary and oral evidence of Witness 1, the daily notes of Resident A dated between 23 February 2023 and 24 February 2023 and your documentary and oral evidence.

In her documentary and oral evidence Witness 5 said that Resident A asked her for some pain relief. Witness 5 told the panel that she passed this request to you. She then told the panel that Resident A came back to her sometime later stating that they had never received their requested pain relief.

In your oral evidence, you told the panel in respect of the administration of medication you would only record the giving of paracetamol to Resident A in their MAR chart if they were having it PRN. Otherwise, you told the panel you would just write *'medication accepted'* in the daily notes. You confirmed that Witness 5 was a

care assistant and not a Registered Nurse and therefore would not be responsible for administering medication and told the panel that if you were asked to provide paracetamol then you would have given it.

The panel noted that no MAR chart was provided for Resident A for this charge. It further noted that you wrote in the daily notes of Resident A on 24 February 2023 '*accepted medications.*' The panel determined that without having sight of Resident A's MAR chart for the date in question, it was not able to confirm if Resident A was the recipient of regular prescribed paracetamol or paracetamol on a PRN basis. As such, the panel determined that there was not any direct evidence to suggest that you failed to document in Resident A's daily notes that you had administered pain relief.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 4d

'That you a registered nurse;

4.On or around 23 February 2023 in relation to Resident A;

d. Failed to score Resident A's pain and/or document a pain relief score.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 1, the daily notes of Resident A dated between 23 February 2023 and 24 February 2023 and your documentary and oral evidence.

In your written statement dated 29 October 2025 you said, '*I consistently assessed residents' pain levels and would document this in their care notes as required*.'

In your oral evidence, you told the panel if you were asked to provide pain relief you would always give it. You clarified that there was a difference between medication

prescribed to be given on a regular basis and medication given on an additional or as needed basis. You told the panel before giving as needed medication you would assess the resident's pain levels and document this in their notes, whereas if a resident received paracetamol as a regular medication, you would write '*accepted medications*' in their daily care notes.

The panel noted that no MAR chart was provided for Resident A for this charge. It further noted that you wrote in the daily notes of Resident A on 24 February 2023 '*accepted medications.*' The panel determined that without having sight of Resident A's MAR chart for the date in question, it was not able to confirm if Resident A was the recipient of regular prescribed paracetamol or paracetamol on a PRN basis. As such, the panel determined that there was not any direct evidence to suggest that you failed to score or document a pain relief score.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 4e

'That you a registered nurse;

4.On or around 23 February 2023 in relation to Resident A;

e. Failed to order paracetamol and/or laxatives for Resident A.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 1, the daily notes of Resident A dated between 23 February 2023 and 24 February 2023, a letter detailing your failed probation dated 16 March 2023, Home Two's medication policy and your documentary and oral evidence.

In her NMC witness statement dated 18 December 2023, Witness 1 said:

'The registrant was also meant to order more paracetamol for Resident A [PRIVATE] as well as laxatives but she failed to do this. She could have asked someone else to do this if she couldn't like me or the deputy manager or the other nurse.'

In a letter dated 16 March 2023 detailing your failed probationary employment period at Home Two, it says;

'*You then informed us that as part of a DST meeting 10th March 2023 relating to this resident that you were requested to order paracetamol and on reviewing the medication records this still had not been completed, you advised that you hadn't recorded this on fusion but recorded this within your own notes but no one had access this (sic)*.'

In your oral evidence, you told the panel that you had never seen this document before and that you had never ordered medication for residents except for on two occasions for specific medication and that you said to management that the medication was required as soon as possible. You told the panel that there were '*Champions*' who were responsible for ordering the '*monthly medications as the paracetamol and things like that.*'

The panel determined that it had not heard any direct evidence at this hearing that you were required to order medication, specifically paracetamol and/or laxatives. The panel also noted that they did not have sight of Resident A's MAR chart specific to the date in question at this hearing and therefore were unable to determine whether paracetamol and/or laxatives were appropriate for Resident A. Further, the panel had sight of the medication policy from Home Two and noted that whilst it detailed the administration, safe storage and disposal of medications, it did not give any indication as to who is responsible for ordering medications.

The panel considered the document dated 16 March 2023 and was of the view that there was not enough evidence that related to Resident A and that it was not tested

during witness oral evidence and your oral evidence. Therefore, the panel attributed little weight to it.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 4f

'That you a registered nurse;

4.On or around 23 February 2023 in relation to Resident A;

f. Declared to Colleague A that you had administered paracetamol to Resident A when you had not.

This charge is found NOT proved.

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

In her NMC witness statement, Witness 5 said:

> '…*one of the residents asked me for some pain relief, I can't remember what it was for, but the resident regularly complained of leg or head pain and was prescribed paracetamol. I went to the registrant and asked them if she would give the resident some paracetamol, she said that she would. This resident is very inpatient and can become verbally aggressive. The resident kept buzzing his buzzer and asking me where his paracetamol was. I went to ask the registrant and she said that she had given it to him. The resident said that he had not had it.'*

In your written statement dated 29 October 2025 you said:

'I have never intentionally misled or been dishonest with any colleague about medication administration. I have no recollection of such a conversation and I would not state that medication had been given unless it had.'

In your oral evidence you told the panel that you would never '*deny a service user their medication when they are prescribed it*.'

The panel had sight of Resident A's daily notes in which you wrote '*accepted medications.'* It also considered that without sight of Resident A's MAR chart it was difficult to know whether Resident A was receiving paracetamol regularly or on a PRN basis and if the MAR chart was signed by you to say that Resident A had received their pain relief. Therefore, without any direct evidence to suggest if you did declare to Colleague A that you had administered paracetamol to Resident A when you had not, the panel found this charge not proved on the balance of probabilities.

Charge 5

'That you a registered nurse;

5. Your declaration in charge 4f was dishonest in that you were attempting to mislead Colleague A that you had administered paracetamol to Resident A when you knew that you had not.

This charge is found NOT proved.

By virtue of Charge 4f having been found not proved, this charge falls away.

Charge 6

'That you a registered nurse;

6. On or around 23 February 2023 failed to provide medication to Resident E.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 5, the daily notes of Resident E dated 23 February 2023 and your documentary and oral evidence.

In her NMC witness statement dates 30 January 2024, Witness 5 said:

> '*I hadn't seen the registrant administer a resident his medication. The resident was diabetic and on antibiotics. I had been in and out of the resident's room and hadn't seen the registrant in there and I knew that he had medication that needed to be administered so I told another nurse, [Witness 10].'*

In her oral evidence, when asked about Resident E and your alleged failure to administer medication, Witness 5 told the panel, "*She usually got the medication as she was eating breakfast*." Witness 5 further told the panel that she had been in the resident's room all day and had not seen you go into the room to administer medication.

In your oral evidence, you told the panel that Witness 5 was not on a one-to-one care with Resident E on the day in question and therefore Witness 5 would not have been with Resident E for the entire day. Moreover, you stated that Witness 5 was a Care Assistant not a Registered Nurse and therefore not responsible for administering medication.

The panel had sight of Resident E's daily notes dated 23 February 2023 which state, '*medications accepted.'* The panel also noted that there were no MAR charts provided of Resident E for the date in question. Therefore, the panel determined that there is no way of knowing what medications had been prescribed for Resident E and if the medications had been administered or not on 23 February 2023.

Further, the panel determined that there were inconsistencies in Witness 5's evidence in that she referred to a resident not being administered medication in her

NMC witness statement as a '*He*' and then in her oral evidence when asked about Resident E not being administered medication, she referred to them as a '*She*.' Without any corroborating evidence as to who exactly Resident E is, the panel were unable to ascertain who exactly Witness 5 was referring to in her NMC witness statement, her local statement and in her oral evidence. Consequently, with Witness 5 the only witness with any evidence for Charge 6, the panel found the evidence to be tenuous and Witness 5 to be unreliable.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 7a

'That you a registered nurse;

7. On 5 March 2023 provided an inadequate handover to Colleague B in that;

a. You could not recall the room numbers of Residents and/or were getting them mixed up.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 4 and your documentary and oral evidence.

The panel noted that in her NMC witness statement dated 11 December 2023, Witness 4 said in relation to 5 March 2023:

> '*You are meant to do a written handover to give to the next person with a list of the resident's rooms and what had been done but she didn't have this, she was just making it up on the spot. She kept getting room numbers and residents names mixed up*.'

Further the panel noted that in Witness 4's local statement written in retrospect on 6 December 2023 she said:

> ‘*NN could not recall the room numbers of the residents and when I told her that there was no one in one of the rooms, she didn’t seem to know but should have been aware as she had been working at Parkville for several months.’*

During her oral evidence, Witness 4 told the panel that her original local statement had been lost and that she had to rewrite it on 6 December 2023, nine months after the alleged incident. She further told the panel that a handover should be written both on the personal computer (PC) system and handwritten as well. She told the panel that their handover consisted of a printout including the name of the person, their room number and then a space to write your notes.

The panel also had regard to your written statement dated 29 October 2025 in which you state, ‘*All handovers were conducted via a computerised system, which displays resident names and room numbers*.’ You confirmed this to the panel during cross examination of your oral evidence.

The panel determined, given all the evidence before it that even if you were unable to recall the room numbers and names of residents, their names and room numbers were on the computerised system. At this hearing, the panel were not provided with any evidence of a printout as to what the handover should have looked like, or any example of notes or the handover you wrote on the day in question printed out from the computer. Therefore, the panel were unable to ascertain what you specifically handed over on the day in question.

The panel further noted Witness 4’s admission in her oral evidence that her original local statement had been lost and that she had to rewrite it on 6 December 2023, nine months after the alleged incident. Whilst it corroborates her NMC witness statement to some extent, the panel determined that they could not put much weight on this piece of evidence due to the fact that it is not a contemporaneous document. Therefore, the panel was of the view that there was not enough evidence before it to determine that you had provided an inadequate handover to Colleague B in relation to Charge 7a.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 7b

‘That you a registered nurse;

7. On 5 March 2023 provided an inadequate handover to Colleague B in that;

b. You provided incorrect information about a resident being in room 25 when there was no resident in that room.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 4 and your documentary and oral evidence.

In her NMC witness statement dated 11 December 2023, Witness 4 said:

> ‘*She kept getting the room numbers and residents names mixed up. She mentioned a resident in room 25 but at the time we didn’t have anyone in room 25. The registrant had been working at the Home for months so she would have known which patients were in which room*.’

In her oral evidence, Witness 4 told the panel that you kept getting names and numbers mixed up and that you were saying room 25 but that there had been nobody in that room for some time.

The panel also had regard to your written statement dated 29 October 2025 in which you state, ‘*All handovers were conducted via a computerised system, which displays resident names and room numbers*.’ You confirmed this to the panel during cross examination of your oral evidence.

Further in your written statement dated 29 October 2025 you said:

'*I had worked in the home since November 2022 and was fully familiar with the residents and their rooms. No concerns were raised with me about my handovers at the time*.'

At this hearing, the panel were not provided with any evidence of a printout as to what the handover should have looked like, or any example of notes or the handover you wrote on the day in question printed out from the computer. Therefore, the panel were unable to ascertain what you specifically handed over on the day. Further, the panel was told in this hearing that the computer system had all the patient names and their corresponding room numbers. The panel determined it is unlikely that the provision of an incorrect room number would result in incorrect information as the name and room number of the resident could be checked on the computer system.

Therefore, the panel was of the view that there was not enough evidence before it to determine that you had provided an inadequate handover to Colleague B in relation to Charge 7b.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 8

'That you a registered nurse;

8. On 5 March 2023 attended work and/or worked whilst under the influence of alcohol.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 1, the documentary and oral evidence of Witness 4, the DNA Workplace Report dated 18 April 2024 and your documentary and oral evidence.

In her NMC witness statement dated 11 December 2023, Witness 4 said:

‘During the handover she looked relay (sic) dishevelled and untidy. She normally wore a wig and looked presentable but on this day, she had no wig on, her uniform was not ironed and she looked generally messy. During the handover she was slurring her words really badly and was confused… I couldn’t tell if it was alcohol or something else, but I suspected she was drunk due to her behaviour and the slurred speech. I didn’t smell any alcohol on her, but she was chewing a lot of gum that day, it looked like she had 10 in her mouth, and was heavily perfumed. I never saw her with any alcohol.’

In her local statement dated 6 December 2023, Witness 4 said;

‘On arriving at the office, I was met by the day nurse on duty NN she was sat in a chair immediately to my right the office is a small space so NN was sitting very close to me, she was slurring her speech whilst giving the handover.’

In Witness 1’s NMC witness statement dated 18 December 2023, she said;

‘ There were suspicions from staff that she had alcohol in her bag and that she smelt of alcohol, these concerns were raised by staff member [Witness 4]. This was then included in our investigation. I suspected on one occasion that I smelt alcohol on her and I raised this with my manager but I thought that it could have been alcohol gel on her hands so it wasn’t taken any further. I know that this was also a concern at her previous Home.’

In your oral evidence, you told the panel that you do not use alcohol except in religious ceremonies/ceremonial purposes in your home country of Zimbabwe, and only used alcohol on these occasions. Further, you told the panel that you would apply hand sanitiser not only to your hands but also to your tabard that you were wearing as Covid was very recent, there was Long Covid in Home One in 2022 and some of the residents were vulnerable. You also told the panel that you did not want to bring anything back home with you. You told the panel that you used your own

hand sanitiser which you brought with you and that the hand sanitiser had "*quite a strong smell*." Further, you told the panel [PRIVATE].

The panel considered Witness 4's admission in her oral evidence that her local statement provided at this hearing was rewritten nine months after the alleged incident due to the first copy being misplaced. The panel noted that there is no mention of alcohol contained in this statement and Witness 4 confirmed in her oral evidence that she never saw you with a bottle of alcohol or under the influence of alcohol that day. The panel noted further inconsistencies with Witness 4's local statement and NMC witness statement as in her local statement there is no mention of you spraying lots of perfume or chewing gum.

The panel noted the DNA Workplace Report test results dated 18 April 2024 which you were asked to undertake as part of the NMC investigation. It noted that you happily complied with the request as soon as you were asked to do so. The panel noted that the delay in completing the test was due to the NMC and not to yourself.

The results demonstrate that there was no finding of excessive alcohol consumption between the period of September 2023 and the end of March 2024. The panel determined that this report indicates that you have been abstinent from consuming alcohol within the assessed timeframe. Further, given evidence given about the differences in rates of hair growth, it is plausible that, although taken some time after the alleged date, the findings may also reflect the period in question. The panel also noted that as a result of there being no expert witnesses to present the DNA Workplace Report findings at this hearing, the results could not be tested. Therefore, the panel determined the evidence contained in this report could only be given some weight. Moreover, the panel determined that there was no direct or independent evidence to support the allegation that you attended work on 5 March 2023 whilst under the influence of alcohol.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 9a

‘That you a registered nurse;

9. On or around 8 March 2023, in relation to Resident F;

a. Failed to follow their care plan when instructing staff to provide them with a pureed diet.

This charge is found NOT proved.

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

The panel considered the NMC witness statement of Witness 5 dated 30 January 2024 in which she stated that on dates 23-24 February 2023 she arrived on shift and one of the carers told her that you had told them to give Resident F pureed food. She said:

> ‘*I told the carer not to give the resident pureed diet as we are already aware of what the resident can and cannot eat and he doesn’t need to be on a pureed diet. I had worked with the residents more than the registrant had so I was more familiar with their needs than the registrant was…His care plan stated that he needed to avoid certain foods but not that he was on a pureed diet.*’

The panel also considered Witness 5’s local statement dated 30 January 2024 in which she stated that on 8 March 2023 ‘*Bezzie was telling me and the other staff to give [Resident F] a soft pureed meal*.’

During your oral evidence, you told the panel that you did not say that Resident F should be given a pureed diet and that there were only two soft diets required in the whole unit. You told the panel that Resident F was on a soft diet and that this was written in their care plan. During panel questions, you were asked if you could explain what the International Dysphagia Diet Standardisation Initiative (IDDSI) diet levels were. You gave a credible explanation: you told the panel that there were

seven graded stages and gave examples in order of solidity. You further told the panel that you knew which resident had the specific diet as there were only two residents on soft diets, there was a matrix posted in the kitchen, the kitchen prepared the meals, and their meals came from the kitchen with stickers. Further, you told the panel that you are learning disability trained and so you are confident that you know the difference between a soft diet and a pureed diet, and what they look like, and who would receive them.

The panel determined that in the absence of any corroborating documentation before them, such as Resident F's care plan, it is difficult to ascertain what diet Resident F should have been on. Therefore, the panel determined that there is not enough evidence to determine whether you did fail to follow the care plan in relation to Resident F.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 9b

'That you a registered nurse;

9.On or around 8 March 2023, in relation to Resident F;

b. Failed to make a SALT referral prior to making a decision that they should have a pureed diet.

This charge is found NOT proved.

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

During cross examination whilst giving her oral evidence, when asked if you thought the care plan was correct, would there be a need for you to make a Speech and Language Therapy (SALT) referral, Witness 1 told the panel that if you felt [Resident

F] required a pureed diet then you would need to make a SALT referral and that if there were no concerns then you would not need to make a SALT referral.

In your written statement dated 29 October 2025, you state that in regard to Resident F, '*The dietary requirements were agreed with the family and clinical lead… on admission*.' Further, during your oral evidence, you told the panel:

> "*They did not need a SALT referral because they were already under a SALT referral diet which they had about a week before coming to our service*."

The panel determined that as a Registered Nurse it would be your duty to make a SALT referral if you had any concerns regarding choking for a resident. However, in the absence of any corroborating evidence before them such as Resident F's care plans that would determine what type of diet Resident F should have been on, and in respect of Charge 9a having been found not proved and therefore there being no evidence that you had any concerns regarding choking for Resident F, there is insufficient evidence to determine whether or not you failed to make a SALT referral in respect of Resident F.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 9c

'That you a registered nurse;

9.On or around 8 March 2023, in relation to Resident F;

a. Failed to document and/or update their care plan/medical notes detailing your reasons why they required a pureed diet.

This charge is found NOT proved.

By virtue of Charge 9a having been found not proved, this charge falls away.

Charge 10a

‘That you a registered nurse;

7. On or around 8 March 2023, failed to provide Colleague A Pro-Cal supplements before breakfast for;

a. Resident B

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 5, the daily notes of Resident B dated 8 March 2023 and your documentary and oral evidence.

In her NMC witness statement dated 30 January 2024, Witness 5 stated:

> ‘*On the 9 March I asked the registrant to get two of the residents Pro Cal supplements for me to give them before their breakfast. I didn’t receive these from the registrant so I carried on with breakfast, she never brought them.’*

In her local statement dated 30 January 2024, Witness 5 said that on 8 March 2023:

> ‘*Bezzie didn’t give the carers Pro-Cal sachets for Resident B or Resident C they have 3 sachets through the day with meals*.’

In her oral evidence, Witness 5 told the panel that she gave the Pro-Cal sachets to residents ‘“*all the time.*”’

In your oral evidence you told the panel that one resident was prescribed a “*Nutricrem”* supplement, which you said was like a yoghurt into which a nurse had to put the Pro-Cal medication. You told the panel that as the nurse on duty, it was your responsibility to give this to the resident as it was covert medication and that it would

not be given to a care assistant to administer. You told the panel that the other resident had a package of care whereby agency staff looked after them on a one-to-one basis from morning until evening. You said that you would give the Pro-Cal supplement to the agency staff to give to the resident and that the agency staff would let you know when the resident has taken the supplement, and you would sign that off. You told the panel you could not remember if it was Resident B or Resident C that had the agency package in place.

When asked why you would not provide Witness 5 with the Pro-Cal supplement to give to the resident, you told the panel that "*it was my job because it had medication inside. I had to make sure they took their medications*."

The panel had sight of the daily notes of Resident B dated 8 March 2023 in which you wrote '*accepted medications reluctantly.*' The panel also had sight of Resident B's MAR chart which indicates by signature that the Pro-Cal supplements were given to Resident B on 8 March 2023 at morning, noon and teatime. The panel determined that given the evidence before them and the lack of clarity as to which resident received the Pro-Cal supplement by covert medication or agency staff, it could not determine that you failed to provide Colleague A Pro-Cal supplements for Resident B before breakfast as the documentary evidence shows that Resident B received their medication. As there is no other corroborating evidence to support Charge 10a, the panel found this charge not proved on the balance of probabilities.

Charge 10b

'That you a registered nurse;

10.On or around 8 March 2023, failed to provide Colleague A Pro-Cal supplements before breakfast for;

b. Resident C

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 5, the daily notes of Resident C dated 8 March 2023 and your documentary and oral evidence.

In her NMC witness statement dated 30 January 2024, Witness 5 stated:

> 'On *the 9 March I asked the registrant to get two of the residents Pro Cal supplements for me to give them before their breakfast. I didn't receive these from the registrant so I carried on with breakfast, she never brought them.'*

In her local statement dated 30 January 2024, Witness 5 said that on 8 March 2023:

> '*Bezzie didn't give the carers Pro-Cal sachets for Resident B or Resident C they have 3 sachets through the day with meals*.'

In her oral evidence, Witness 5 told the panel that she gave the Pro-cal sachets to residents "*all the time."*

In your oral evidence you told the panel that one resident was prescribed a "*Nutricrem*" supplement, which you said was like a yoghurt into which a nurse had to put the Pro-Cal medication. You told the panel that as the nurse on duty, it was your responsibility to give this to the resident as it was covert medication and that it would not be given to a care assistant to administer. You told the panel that the other resident had a package of care whereby agency staff looked after them on a one-to-one basis from morning until evening. You said that you would give the Pro-Cal supplement to the agency staff to give to the resident and that agency staff would let you know when the resident has taken the supplement, and you would sign that off. You told the panel you could not remember if it was Resident B or Resident C that had the agency package in place.

When asked why you would not provide Witness 5 with the Pro-Cal supplement to give to the resident, you told the panel that '"*it was my job because it had medication inside. I had to make sure they took their medications*."'

The panel had sight of the daily notes of Resident C dated 8 March 2023 in which you wrote '*accepted medications.*' The panel noted that although it was provided with a MAR chart for Resident C, the date on the MAR chart begins 3 April 2023 which is not the same date as the date in question. The MAR chart for the date in question was not given. The panel therefore determined that given the lack of clarity as to which resident received the Pro-Cal supplement by covert medication and by agency staff, it could not determine that you failed to provide Colleague A with a Pro-Cal supplement for Resident C and with no other corroborating evidence to support Charge 10b, the panel found this charge not proved on the balance of probabilities.

Charge 11c

'That you a registered nurse;

11. On 10 March 2023, in relation to Resident D;

a. Failed to complete and/or sign a body map indicating the location of the applied Butec Patch.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 1, The medication policy of Home Two and your oral and documentary evidence.

In her NMC witness statement dated 18 December 2023, Witness 1 said:

> 'We *also have a patch administration chart which we sign when the patch has been put on. We then do checks of the patch for seven days. You need to also do a body map where you put the patch and document it and sign it, then every day after administering the patch you sign to say that it is still on the skin. None of this was completed. [Home Two] has been unable to find the patch charts for these days*.'

In your witness statement dated 29 October 2025 you said:

> '*The patch was applied correctly; the old patch was removed and the new site checked in accordance with procedure and I completed all documentation. I applied the patch on a different side of the resident's body after checking where the previous patch was placed and completed all documentation required*.'

In your oral evidence, you told the panel how you would initial and put the date on the Butec patch prior to applying it. You confirmed that you would remove the old patch first and apply the new Butec patch to a different area on the other side of the resident's body. Further you told the panel that you would indicate what site you had applied the Butec patch and document that in your notes.

Taking all of the above into consideration, the panel noted that as a registered nurse, you had a duty to apply the Butec patch as prescribed. However, in the absence of any documentation that specifically states that you were required to complete and/ or sign a body map after the application of the Butec patch, and after reviewing the medication policy of Home Two, which does not indicate this either, and in the absence of any patch charts, whether complete or incomplete, the panel was of the view that there was not enough evidence to determine that you failed to complete and/or sign a body map indicating the location of the applied Butec patch.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 11d

'That you a registered nurse;

11. On 10 March 2023, in relation to Resident D;

a. On one or more occasions failed to sign and/or check that the Butec Patch was still attached to Resident D once applied.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 1, The Medication Policy of Home Two and your oral and documentary evidence.

In her NMC witness statement dated 18 December 2023, Witness 1 said:

> '*This is basic medication administration. We also have a patch administration chart which we sign when the patch has been put on. We then do checks of the patch for seven days. You need to also do a body map where you put the patch and document it and sign it, then every day after administering the patch you sign to say that it is still on the skin. None of this was completed. [Home Two] has been unable to find the patch charts for these dates.'*

In her oral evidence, Witness 1 told the panel that once applied, the Butec patch should be checked every day.

In your oral evidence, you told the panel that you were not working every day and, in any case, the Butec patch did not need to be checked every day as "*it was a big patch, it was not going anywhere. You only changed it every seven days*."

The panel noted that whilst there was no specific medication policy at Home Two that detailed the administration and maintenance of a Butec patch, the medication policy of Home One, stated:

> '*Medication should be administered by a registered first level nurse, CHAPS or by a designated, appropriately trained member of staff… Staff should also check the medication name, the strength of the medication, the dosage instructions, and the expiry date. Controlled drugs should always be double-checked by a second suitably trained member of staff in the absence of a local procedure/risk assessment.*'

Therefore, the panel determined that as a Registered Nurse, you had a duty to sign and check any medication and follow the NMC code of conduct. The panel determined in your admission that you did not need to check the Butec patch on Resident D every day that you failed to do this and accordingly, the panel found this charge proved on the balance of probabilities.

Charge 15a

'That you a registered nurse;

7. On 14 March 2023

    a. Left medication unattended on the medication trolley.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 4 and your documentary and oral evidence.

In her NMC written statement dated 11 December 2023, Witness 4 said:

> '…*so I went to the medication trolley to get a syringe to administer medication. I reached my hand in the basket which had the syringes in in (sic) packets on top of the medication trolley and found a packet that was full of medication. The syringe had been taken out, but the packet had been filled with medication.*'

She further said:

> *'I knew it was the registrant as she was on the shift before me, and she would be the only person who had access to the medication trolley that day.*'

During panel questions, Witness 4 told the panel she conducted an audit of the medication trolley every night, but this did not include a thorough search of the basket on top of the trolley where the medication was found, and that this basket was ‘deep’ and items could remain in it for long periods of time.

In your oral evidence, you told the panel that there had been numerous incidents of medications being left inappropriately and that you reported this.

The panel determined that there is a lack of evidence before it that is able to corroborate Witness 4’s account of events. The panel noted that there is no evidence of any audit documentation that would indicate what was checked and not checked the night before the alleged incident occurred. The panel also noted that during her oral evidence, Witness 4 admitted that the medication could have been there for some time. Therefore, there is no direct evidence to suggest that you left the medication on the trolley. The panel further noted that there were no issues raised in relation to your medication administration or storage during a [Home Two] Medication Administration Competency Assessment conducted by Witness 1 on 7 January 2023. This competency assessment did not raise any concerns regarding your handling of the medication trolley.

In the absence of any direct evidence the panel found this charge not proved on the balance of probabilities.

Charge 15b

‘That you a registered nurse;

15.On 14 March 2023

b. Failed to keep medication locked away and/or secure from access.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 1, the documentary and oral evidence of Witness 4 and your documentary and oral evidence.

In her NMC written statement dated 11 December 2023, Witness 4 said:

> *'I knew it was the registrant as she was on the shift before me, and she would be the only person who had access to the medication trolley that day.*'

During her oral evidence, Witness 4 told the panel that she would conduct an audit on the medication trolley every night, but this did not include the basket on top of the trolley where the medication was found. Witness 4 also admitted that the medication could have been there for some time.

During your oral evidence, you told the panel that there were numerous occasions where you found medication in an inappropriate place and that you reported this.

The panel noted that no audit documentation was presented to it at this hearing to confirm that an audit took place the night before the alleged incident occurred and what areas of the medication trolley were checked or not checked. The panel further noted that there were no issues raised in relation to your medication administration or storage during a [Home Two] Medication Administration Competency Assessment conducted by Witness 1 on 7 January 2023. This competency assessment did not raise any concerns regarding your handling of the medication trolley or in keeping it locked and secure. In the absence of any direct evidence that you failed to keep medication locked away and/or secure from access, the panel found this charge not proved on the balance of probabilities.

Charge 16

'That you a registered nurse;

12. On one or more occasions, other than that in charge 8, attended work and/or worked whilst under the influence of alcohol.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 5, the documentary and oral evidence of Witness 1, and your documentary and oral evidence.

In Witness 5's NMC witness statement dated 30 January 2024, in relation to Charge 16 she said:

> '*On one occasion she was slurring her words and she smelt of alcohol so I raised this with the Home Manager. I never saw her with any alcohol.*'

In her NMC witness statement dated 18 December 2023, Witness 1 said:

> '*There were suspicions from staff that she had alcohol in her bag and that she smelt of alcohol, these concerns were raised by staff member [Witness 4]. This was then included in our investigation. I suspected on one occasion that I smelt alcohol on her and I raised this with my manager but I thought that it could have been alcohol gel on her hands so it wasn't taken any further*.'

In your oral evidence, you told the panel that you do not use alcohol except in religious ceremonies/ceremonial purposes in your home country of Zimbabwe and only used alcohol on these occasions. Further, you told the panel that you would apply hand sanitiser not only to your hands but also to your tabard that you were wearing as Covid was very recent, there was Long Covid in Home One in 2022 and some of the residents were vulnerable. You also told the panel that you did not want to bring anything back home with you. You told the panel that you used your own hand sanitiser which you brought with you and that the hand sanitiser had "*quite a strong smell*". Further, you told the panel [PRIVATE].

The panel considered the wording of Charge 16 to be vague in that it does not point to any specific incident or date. Therefore, the panel found that due to the absence of any direct evidence presented in regard to Charge 16, the evidence that was presented was consequently insufficient.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 19

19. On 6 September 2023 physically abused Resident A.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 6, the documentary and oral evidence of Witness 7, the photos of Resident A and your documentary and oral evidence.

In your written statement regarding the incident on 6 September 2023, you said:

> *'Resident A had visible injuries before I commenced my shift that day. I noted this immediately and attempted to report it to the nurse in duty, she told me she was busy as it was her first time working in the home…At the start of the shift, Resident A was sitting on a chair near the window rather than her usual seat. At around 2pm she began rolling on the floor and staff placed a pillow under her head to prevent further injury. Any bruising may have worsened during these episodes, but the marks were already present when I started my shift.'*

In the incident statement dated 8 September 2023, you said that you had asked the nurse in charge for a handover for Resident A upon starting your shift that day. You said that you told the nurse in charge about the bruising on Resident A's face and the nurse in charge said that they did not know anything about that. You mentioned that you had told a different nurse in charge a few days before and they told you it

could be because Resident A was on blood thinners. You said as the day went on Resident A became more unsettled and you requested PRN medication from the nurse, which was not given. You also said that you tried other techniques and distraction to try and settle Resident A. In regard to the incident on the date in question you said:

> *'I took my 1:1 to her room offered her a shower. During this another resident came coming (sic) in the bedroom of my 1:1 and she was getting annoyed and began shouting and attempting to grab at that resident we were sitting on the couch. My 1:1 stood up flipped her zimmer frame in annoyance pushed the door with force and locked it [PRIVATE]…My 1:1 sat back appearing emotional, so while comforting her without warning she grabbed my arm and bit me in a split second I shouted for help nobody came her room does not have a functioning alarm to activate.'*

In Resident A's daily notes dated 6 September 2023, you reported:

> '*At 12:00-12:35, In the lounge. Bruise on left side of face under eyelid...13:55-14:50, In bedroom throwing things everywhere. Urinated on floor. Threw herself on the floor attacking 1:1 Staff with zimmer frame, and bedside table. Very angry. Refused change of environment.'*

In your oral evidence, you confirmed this version of events to the panel.

In NMC witness statement dated 15 February 2024 Witness 7 said:

> '*At around 16:00 I was doing my second medication round and Resident A was in her bedroom. I went to Resident A's bedroom to give her her (sic) medication and I heard Resident A screaming "help me help me". I tried to open her bedroom door, but the door was locked. I said "are you OK" and the registrant replied "hold on" so I went back to the office where the medication trolley was kept and put*

back Resident A's medication. I then went back to Resident A's room and said "are you OK" again and I heard the registrant say "don't hit me don't hit me" and she told me to hold on again. I then went to the dining room as I couldn't open the door…The registrant then came into the dinning (sic) room and asked me why I didn't help her and said that the resident was attacking her. I told her that I knocked on the door twice and asked if she was OK and that she had told me to hold on. I then went to the Resident A's room to see her and she was with another carer. Her bedroom was a mess, the pillows from her bed were all over the floor. Resident A was bleeding from her mouth and had a big bruise on and around her eye. She was also holding her hand behind her back. I asked her to show me her arm and she refused. She was shaking and terrified…The bruise on her eye was big and black so I went back to the registrant and asked her what happened. The registrant said that Resident A was attacking her and pushed her. I asked her why the door was locked, and she said that Resident A had locked the door. She was very defensive, and I explained that I needed to know had happened. I asked the registrant what happened to Resident A's hand as it was bleeding and she told me that it wasn't blood, but it was from the strawberries she was eating…Every room at The Home as (sic) an emergency buzzer so the registrant should have pulled this for help.'

She further stated:

'*I saw Resident A in the lounge before the incident, and I didn't see any of the injuries that were there after the incident. The registrant had said that Resident A had the bruise before the incident, but this wasn't documented anywhere. When I took the photographs of Resident A after the incident, there was a small yellowish bruise on her scalp, indicating that it was an older bruise but after the incident she had a new black bruise that wasn't there before*.'

In her NMC witness statement dated 14 February 2024, in relation to the incident and the buzzers in Resident A's room, Witness 6 said:

> '*Each room has an emergency buzzer which the registrant should have pressed if she was having any issues with Resident A. We had recently had our buzzer system replaced so I know for certain that all of the buzzer's were working. We ran a report which showed that the emergency buzzer in Resident A's room hadn't been pressed on the day of the incident.'*

Witness 6 further said, '*I didn't see Resident A before the incident, but a member of staff stated that she did not have the bruising before the incident.*'

In her oral evidence, Witness 6 confirmed to the panel that Resident A could be a difficult resident and that she suffered from vascular dementia. She told the panel that Resident A would shout and appear angry at times, "*she would put herself down on the floor and you couldn't move her because she would lash out*." Witness 6 also told the panel that Resident A had "*flipped a dining room table*" before.

Taking all the evidence into consideration, the panel noted that there were no eyewitnesses of the alleged physical abuse of Resident A or any CCTV evidence that may assist in proving a version of events. The panel also noted further missing evidence that would have assisted at this hearing such as:

- Documentary evidence indicating where buzzers were located in Home Three, which would confirm whether or not Resident A had a buzzer in their room,
- Documentary evidence of the report which the home ran which would indicate whether the buzzer had or had not been activated (although it was noted that if the buzzer did exist and was not operating a report would indicate that it had not been rung, so only marginal weight was given to this),

- The bottom page of Resident A's daily notes which has been cut off and therefore precluding the panel from seeing what happened after your entry at 14:50,
- Resident A's daily notes from preceding days which would independently give light onto what bruising did or did not exist before the day in question,
- A copy of the nurses notes in the days preceding the incident in order to corroborate or disprove the presence of preexisting bruising on the face of Resident A,
- A list of medication taken by Resident A to corroborate or disprove she had been prescribed blood thinning medication,
- Contemporaneous notes or a witness statement of Ms 1, the clinical lead, who was the senior nurse and was there on the day, attended immediately after the event and took a statement from you, nor was Ms 1 called as a witness,
- Contemporaneous notes from Witness 6 who attended immediately after the event,
- A copy of the Duty of Candour report conducted as part of the investigation by Home Three into this incident.

Further, the panel noted that there was inconsistency in terminology throughout of written and oral evidence. Notes were variously referred to as, '*patient notes'*, '*diary notes'*, '*diary for one-to-one'*, etc. There was no clarification as to the differences between types of records nor which staff member was responsible for maintaining which type of record.

In addition to this, the panel considered there to be inconsistencies with Witness 7's local statement. Further, there is confusion even as to whether the local statement can be reliably attributed to Witness 7 as the same document also attribute it to Witness 6. Moreover, rather that producing fresh and independent statements in the incident report and other documentation, portions of what purports to be Witness 7's statement has been copied and pasted throughout and is the only written evidence that exists. It is referred to as belonging to Witness 6 in one report and another staff member in a different report. The panel noted that this is misleading and unreliable as a result the panel gave this evidence less weight.

The panel noted that the safeguarding report also had cut and pasted portions of this same statement and contradictions about capacity.

Further, the panel had sight of the photos of Resident A's face taken by Witness 7. The panel considered that the signs of bruising and redness around Resident A's eyes appears to be consistent with your written statement and your oral evidence and with Resident A's daughters' report. The panel also noted that there were no photos of any other relevant areas of Resident A's face.

The panel noted that you were consistent in your evidence under oath. It noted that you had good understanding of the behaviour and presentation of Resident A and that you were credible and consistent under oath in your knowledge of the Resident and in explaining the strategies you would use to distract and calm the Resident when they were agitated and exhibiting challenging behaviour. You were specific about her preferences in fruit, in which chair she preferred to sit in and how she would interact with other Residents.

The panel noted that you had worked with Resident A for 5 weeks without any other allegations of the same sort. It was also mindful that this charge falls under one of three referrals being considered at this hearing. The panel noted that there were no allegations of this sort in either of the two other referrals which taken together, have been investigated for a significant period of time and there is no suggestion that any incident of this sort has occurred previously.

Therefore, due to a lack of eyewitnesses and tenuous evidence to suggest that you physically abused Resident A, the panel found this charge not proved on the balance of probabilities.

Charge 20a

20. On 6 September 2023 documented the following incorrect entries in Resident A's diary for one to one;
    a. '*Top of eyelid red and left side of forehead has a bruise'*, not timed.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 6, the documentary and oral evidence of Witness 7 and your documentary and oral evidence.

In her NMC written statement dated 14 February 2024, Witness 6 said:

> '*On the 6 September 2023, the Nurse on Duty [Witness 7], came to me and told me that Resident A had bruising on her face. I went with the Clinical Lead [Ms 1] to see what had happened. When I saw Resident A, she had bruising above and below both of her eyes. The registrant had spoken with me that day at lunch time in my office about extra shifts but she hadn't mentioned the incident or that Resident A had any injuries*.'
>
> '*I didn't see Resident A before the incident, but member of staff stated that she did not having the bruising before the incident. When I looked at these notes, the entry for the morning documenting the bruising, looked like it was added at a later date as it was added to the top of the page and didn't have any time documented.*'

In her NMC witness statement dated 15 February 2024, Witness 7 said:

> '*I saw in the lounge before the incident and I didn't see any of the injuries that were there after the incident. The registrant had said that had the bruise before the incident, but this wasn't documented anywhere.'*

In your written statement dated 29 October 2025, you said:

> '*I did make entries in Resident A's records as part of my duty to document observations. The entries accurately reflected what I saw:*

redness to the eyelid and bruising to the forehead. I reported these findings to the nurse in charge as soon as she was available.'

In the incident statement dated 8 September 2023, you said that you had asked the nurse in charge for a handover for Resident A upon starting your shift that day. You said that you told the nurse in charge about the bruising on Resident A's face and the nurse in charge said that they did not know anything about that.

In your oral evidence, you told the panel that this entry was not incorrect and that as you started your shift that day at 12:00 and the morning timings of 6am-8am were scratched out, therefore you started your recording of your notes in that box, "*that's when I started my 12 till 12:35 on the documentation of it."*

The panel also noted the documentary evidence of the patient notes was missing the relevant time points from before and after the incident and from the days leading up to the incident.

The panel noted that one page of the patient notes was in a different format to the others but was of the view that you gave credible explanation in your oral testimony that you used the papers as you found them in the patient's folder and that it was not your responsibility to provide these forms. Further, the panel noted that you were asked to leave the Home before the end of your shift and therefore would not have had the opportunity to provide a diary entry after the incident.

The panel also considered the inconsistencies in the testimony of Witness 6 who in oral testimony said, '*There were no morning recordings from 8 to 12 - I was very concerned about it'* and under questioning, confirmed that you were on an 8 to 8 shift, when in fact you were on a 12-12 shift. This reduced the reliability of Witness 6's evidence and as a result the panel gave less weight to it.

The panel determined that there is a lack of evidence to support the allegation that you documented an incorrect entry in Resident A's diary.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 20b

20.On 6 September 2023 documented the following incorrect entries in Resident A's diary for one to one;

b. 'Resident A in the lounge. Bruise on the left side of face under eyelid', timed at 12.00 – 12.35.

This charge is found NOT proved.

Following on from the reasoning applied in reaching the decision for Charge 20a, in reaching the decision for Charge 20b, the panel took into account the documentary and oral evidence of Witness 6, the documentary and oral evidence of Witness 7 and your documentary and oral evidence.

In her NMC written statement dated 14 February 2024, Witness 6 said:

'*On the 6 September 2023, the Nurse on Duty [Witness 7], came to me and told me that had bruising on her face. I went with the Clinical Lead [Ms 1] to see what had happened. When I saw, she had bruising above and below both of her eyes. The registrant had spoken with me that day at lunch time in my office about extra shifts but she hadn't mentioned the incident or that had any injuries*.'

'*I didn't see before the incident, but member of staff stated that she did not having the bruising before the incident. When I looked at these notes, the entry for the morning documenting the bruising, looked like it was added at a later date as it was added to the top of the page and didn't have any time documented*.'

In her NMC witness statement dated 15 February 2024, Witness 7 said:

'*I saw in the lounge before the incident and I didn't see any of the injuries that were there after the incident. The registrant had said that*

had the bruise before the incident, but this wasn't documented anywhere.'

In the incident statement dated 8 September 2023, you said that you had asked the nurse in charge for a handover for Resident A upon starting your shift that day. You said that you told the nurse in charge about the bruising on Resident A's face and the nurse in charge said that they did not know anything about that.

In your oral evidence, you told the panel that this entry was not incorrect and that as you started your shift that day at 12:00 and the morning timings of 6am-8am were scratched out, therefore you started your recording of your notes in that box, "*that's when I started my 12 till 12:35 on the documentation of it."* You told the panel that you documented everything that day as soon as you saw it and that you told the nurse in charge. You told the panel you took Resident A to their room and documented your observations in their file.

In your written statement dated 29 October 2025, you said:

'*The documentation was made in good faith and recorded what I had observed. Resident A's facial bruising was already present*.'

The panel determined that there is a lack of cogent evidence to support the allegation that you documented an incorrect entry in Resident A's diary.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 21

21. Your actions in charge 20a and/or 20b were dishonest in that you were attempting to conceal from others that you had physically abused Resident A.

This charge is found NOT proved.

By virtue of Charges 20a and 20b having been found not proved, this charge falls away.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether 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

Mr Malik referred to the cases of *Calhaem v GMC [2007] EWHC 2606 (Admin)*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Malik 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.

Mr Malik identified the specific, relevant standards of the Code that the NMC assert were breached as a result of your conduct: 1.2, 1.4, 10.1, 10.2, 19.1 and 20.1.

Mr Malik submitted that the concerns in this case are serious and relate to your failures in fundamental clinical areas of nursing practice. In respect of Charges 2 and 3, he submitted that your failure to administer medications to vulnerable residents and failure in record keeping mean that residents may receive care that is unsafe and does not meet their health needs. He submitted that one of the fundamental aspects of nursing is to provide safe and competent care to patients, and that administering and managing medications is at the heart of safe nursing practice. Mr Malik submitted that not administering medication and recording the administration of medication puts patients at risk of harm and that you know the importance of record keeping.

Mr Malik submitted that Charges 11a, 11b, and 11d found proved are also serious charges. He submitted that you failed to sign or check that the Butec patch was attached to Resident D and therefore there was a potential risk of harm to Resident D. He submitted that you failed in basic nursing.

Mr Malik submitted that your overall conduct is a serious matter and that your failings are clear examples of misconduct, falling far short of that which would be deemed proper conduct of a professional and that these errors go against the basic and fundamental matters of patient care. He submitted that part of the role of nurses is to provide safe and effective care to patients and a failure to do so, places patients at a serious risk of harm. He submitted that as the misconduct in this case occurred in your workplace, it related directly to your clinical practice.

Mr Malik submitted that your conduct in this case is a serious departure from the Code and that fellow practitioners would consider such a departure as deplorable. He submitted that your conduct is a serious departure from the standards expected of a Registered Nurse and as such, the facts are sufficiently serious to constitute misconduct.

Ms Curzon referred the panel to the relevant case law of *Roylance,* Meadow v General Medical Council [2006] EWCA Civ 1390, *R (Remedy UK ltd) v General Medical Council* [2010] EWHC 1245 Admin and *Nandi*.

Ms Curzon submitted that not every falling short of acceptable practice amounts to professional misconduct of a gravity that crosses the threshold at which a registrant's fitness to practice mat be subject to scrutiny. She submitted that mistakes are an ordinary part of human life and that nobody gets through their professional career without making a mistake.

In respect of Charges 2 and 3, Ms Curzon submitted that both of these charges are in relation to the same shift from the same date of 30 October 2022. She submitted that it is important that one looks closely at the context of these charges and that overall, the failures relating to the charges found proved in respect of Charges 2 and 3 occurred on a single shift. She submitted that this was your second ever shift in the ward and constitute a one-off discrete incident where [PRIVATE]. She submitted that on this date, the situation in the ward was less than ideal. She submitted that you were in a position where you were the nurse in charge of two wards with 15 to 20 residents in each ward, and that these wards were also separated by a car park. In addition to this, she submitted that there were staffing issues due to recent resignations and that during the fact-finding stage of this hearing, the panel heard from you that you had to respond to buzzers and assist agency care staff who were also unfamiliar with the ward. She submitted that you explained that there were difficulties in administering medication to some of the residents due to them being asleep or refusing to take their medication. Ms Curzon submitted that delaying administration of medication is the correct way to deal with the administration of medication for those patients and in accordance with the Code.

Ms Curzon submitted that you accept wholeheartedly that you were running late in regard to medication administration on this shift and that you have taken accountability for your actions and [PRIVATE]. She submitted that your actions were not exclusively due to your practice and that you were required to leave your shift before being able to complete administering the medications with which, understandably in the context, you were running late. Ms Curzon submitted that you

accepted in evidence that your method of completing the MAR charts on this date was not best practice. However, you were asked to leave, you were unable to complete the MAR charts via your method. Therefore, in the context of running late, other pressure and being asked to leave, it was not possible to administer all the medications or complete the MAR charts. Ms Curzon submitted that in the context of:

- This ward,
- A single shift on a single day,
- [PRIVATE], some of which were beyond your control and where there was no patient harm.

Charges 2 and 3 do not cross the threshold to amount to serious professional misconduct. She submitted that your failures may be examples of failing to reach the standard of a professional nurse, but do not pass the threshold of seriousness such that a fellow practitioner would consider your conduct deplorable or as gross professional negligence.

In regard to Charges 11a, 11b and 11d, Ms Curzon submitted that these charges relate to one resident on a single date, 10 March 2023. Ms Curzon submitted that as explained in your witness statement and your admissions:

- It is accepted that Charge 11a was as a result of an oversight,
- Charge 11b was an admission and that you explained that your colleague had signed the MAR chart instead of the patch administration chart.

Ms Curzon submitted that whilst not obtaining a second signature is not best practice, it does not meet the threshold to amount to serious professional misconduct. Ms Curzon submitted this is particularly the case as colleagues on the ward would have been aware of the application of the Butec patch by virtue of the completed and signed MAR chart.

In relation to Charge 11d, Ms Curzon submitted that those on the ward would have been aware of the application of the Butec patch by virtue of the completed MAR

chart and drew the panel's attention to the fact there is no mention of any requirement or need to sign or check the Butec patch is still attached on the day of its administration. She submitted that this charge does not cross the threshold to amount to serious professional misconduct.

Ms Curzon submitted that you accept your shortcomings in the charges found proved, you have apologised and you have taken accountability. She submitted in the specific [PRIVATE] on your shift on 30 October 2022 and in the context of signing various forms on 10 March 2023, there was no patient harm in either incident. She emphasised that your conduct does not fall far below the standard expected of a Registered Nurse nor would be considered deplorable in those specific circumstances by fellow practitioners. She submitted that in respect of the charges found proved that they do not amount to serious professional misconduct.

Submissions on impairment

Mr Malik 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 *Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2008] EWHC 581 (Admin) and NMC guidance FTP-15 namely '*Insight and strengthened practice'* last updated 14 April 2021.

Mr Malik submitted that your practice is currently impaired. He directed the panel to the case law of *Grant* and submitted that the limbs *a*, *b* and *c* are engaged in this case. He submitted that limb *d* is not engaged in this case as the panel did not find you to be dishonest. In regard to limb *a,* he submitted that whilst there is no evidence of patient harm having been caused by your actions, your actions and inactions exposed vulnerable patients to an unwarranted risk of harm. He submitted that your failures in medication administration and record keeping put patients at a serious risk of harm as vulnerable patients would have gone for prolonged periods without their medications. He submitted that you have breached the fundamental tenets of the

nursing profession and that your actions are a serious departure from the standards expected of a registered health professional.

Mr Malik submitted that your failings in this case are directly linked to your clinical practice and referred the panel to your impairment bundle which includes your reflection statement, testimonials and training certificates. He submitted that some of your testimonials are not very recent as they are dated from 2023. In relation to your reflection, Mr Malik submitted that you deny that you failed to administer medications to vulnerable patients and that in your reflection you say, '*I believe I am safe*.' He submitted that the charges found proved, clearly indicate that you are not safe. Mr Malik submitted that the concerns found proved are serious and that your insight is still developing. Therefore, he submitted that there is a risk of repetition. He submitted that the concerns have not been remediated and therefore are highly likely to be repeated should you be permitted to practice as a nurse again. He submitted there is a continuing risk to the public due to your lack of full insight. Mr Malik submitted that you have displayed insufficient insight into the seriousness of the concerns and that your fitness to practice remains impaired. He submitted that a finding of impairment is necessary in order to protect the public.

Mr Malik submitted that the concerns of the matters found proved have not been remediated and are highly likely to be repeated if you were to practice again. He submitted that your conduct engages the public interest as there is no evidence that you have shown sufficient insight into the issues raised and the public would expect the NMC as a regulator to ensure that those on its register maintain the required standards of professionalism. He submitted that a member of the public would expect the NMC to regulate and restrict the practice of nurses whose behaviour remains liable in the future to put patients at unwarranted risk of harm. As such, Mr Malik submitted that a finding of impairment is necessary.

Ms Curzon referred the panel to the relevant case law of *R (Zygmunt) v General Medical Council* [2008] EWHC 2643 (Admin) and *Cohen*.

Ms Curzon submitted that where you have previously denied some charges, this should not amount to a lack of insight and asked the panel to take a holistic view of

the circumstances of this case.

Overall, Ms Curzon submitted that your practice is not currently impaired and that you have demonstrated an ability to practise kindly, safely and professionally in the years since these charges occurred. She submitted that you have been working full time for over two years since these charges as a Senior Healthcare Assistant and that you have established a track record of having worked kindly, safely and professionally in a healthcare setting.

Ms Curzon submitted that in the time since you qualified in 2014 and prior to these proceedings, you had an unblemished professional and personal history. She submitted that your conduct is remediable and that there has been no repetition of any of the concerns or any complaints in the three years since the allegations of Charges 2 and 3 and in over two years for Charges 11a, 11b and 11d. She submitted that if the charges are found to have amounted to misconduct, they do not present a pattern of behaviour. She submitted that the charges found proved relate to one isolated, challenging shift on October 2022 and one issue with signatures on forms in March 2023.

Ms Curzon submitted that you have continued to work in the healthcare profession as a Senior Healthcare Assistant and the fact there have been no concerns raised or complaints about your practice speaks volumes. She submitted that the references contained within your impairment bundle are overwhelmingly positive and confirm your professionalism, reliability and kindness towards patients and residents. She further submitted that this case has taken over two years since the third referral to reach this stage and during that time, it shows that you are capable of safe and effective practice without the repetition of the concerns raised.

In regard to insight, Ms Curzon referred the panel to your reflection statement and submitted that it shows a detailed level of insight and awareness into your practice, where you went wrong and identifies and articulates the risks that would be placed on residents by virtue of your actions. Ms Curzon submitted that you are able to identify what steps you would take if you were faced in a situation like you found yourself in October 2022. She submitted that you take full accountability for your

actions and look at what you could have done better and what could be approached differently in the future and how you would do this. In relation to the administration of medication and record keeping specifically, Ms Curzon submitted that you provide a detailed reflection of what is expected of you as a nurse and that you show a clear understanding of the risks posed to residents if one does not abide by the Code and professional standards. She submitted that your reflection statement shows a clear understanding of what is required by a Registered Nurse, an awareness of risks and an assurance that you will adhere to the relevant guidelines and procedures if permitted to return to practice.

Ms Curzon submitted that in terms of your professional development, you have described how you have maintained your clinical knowledge and skills through continuous professional development (CPD), reading and that you have been active whilst working as a healthcare assistant in giving handovers and making sure care plans are being followed. Ms Curzon submitted this is supported in a reference from a registered professional and your current Nursing Home Manager, Ms 2. Ms Curzon submitted that the CPD that you have undertaken is extensive and targeted in that the courses you have completed go to the heart of the concerns in this case, namely '*Medication Competency'*, '*Medication Administration'*, '*Record Keeping'*, '*Duty of Care'* and courses on Adult and Child safeguarding. She further submitted that you explained in your reflection statement how these courses have influenced you, what you have learnt from them and that you now focus more on time management, prioritising your workload and working as part of a team. She further submitted that you have regular meetings with a former chief nurse where you have had a chance to discuss your learning from this process and progression within the nursing profession.

Ms Curzon submitted that the references that have been submitted attest to your kindness and professionalism and that this is a recurring theme within them. She submitted that looking at the remediation undertaken, your reflective statement, the CPD and insight, you do have deep insight into what you have done and what you must do to continue if you want to be able to continue to practice in this profession. She submitted that there is very little risk of repetition given the extensive level of insight that you have demonstrated and the fact that you have continued to work in

the healthcare system with the accompanying pressures of that system without any complaints or concerns in over two years of practice is the strongest evidence possible to support that there is the unlikelihood of any risk of repetition.

Ms Curzon submitted that the public protection and public interest grounds are not engaged in this matter. She submitted that your safe practice in caring for vulnerable patients in the years since the allegations arose, demonstrate that you present no current risk to patients. She submitted that the actions of the charges found proved do not amount to a pattern of behaviour. In the circumstances, in the absence of any repetition and the level of insight you have shown, Ms Curzon submitted that public protection is not a ground that is engaged in these circumstances.

In regard to public interest, Ms Curzon submitted that public confidence in the profession is critical. She submitted that public confidence in this case is not undermined as you have practised safely in the healthcare sector for years after the incidents and have shown genuine insight and remedied the concerns in this case. She submitted the strongest factor in supporting why public interest is not engaged in this case is that your former employer Agency Two, sought to reemploy you whilst these proceedings were ongoing. She submitted that a return to unrestricted practice for you does not undermine public confidence or threaten public safety. She submitted that if your former employer has the confidence and trust in your practice to reemploy you, then public confidence in your ability to practice kindly, safely and professionally is also satisfied.

Regarding all the circumstances, Ms Curzon invited the panel to find your fitness to practice not currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance, Calhaem, Meadows, Zygmunt and Grant.* It also included reference to NMC Guidance DMA-1 namely '*Impairment*' last updated 3 March 2025.

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. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
>
> ***14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place***
> *To achieve this, you must:*
> ***14.3** document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*
>
> ***16 Act without delay if you believe that there is a risk to patient safety or public protection***
> *To achieve this, you must:*
> ***16.3** tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can*
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***
> *To achieve this, you must:*
> ***19.1** take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 *identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In considering the issue of misconduct, it had regard to the contextual background in the particular circumstances of this case.

With regard to Charge 2 and your failure to administer medication to residents, the panel determined this related to one of the fundamental areas of clinical practice as a nurse.

The panel considered the contextual factors around this incident. The panel heard evidence that the incident occurred on one single shift and that it was your second shift ever on the ward. The panel heard that you [PRIVATE] in that you were the sole nurse in charge of two wards, which were situated across a car park from each other and that there were staff shortages. The panel heard that in the middle of administering medications, you had to assist agency care staff who were also unfamiliar with the ward and answer buzzers. This had an impact on your timings for giving the medications to residents and administration was further exacerbated by patients sleeping or refusing medications which meant you could not administer medication to those residents, which in turn delayed rounds to administer medication later in the day. The panel also had regard to the testimony of Witness 2 who said:

'The registrant would have responsible for Spring and Summer units if she worked on 30 October 2022. This wasn't unusual to be working for both the units, our staff worked across both units. There wouldn't have been many people on the units, so the workload was manageable, and we were fully staffed over both the units.'

Witness 2 reiterated this in oral testimony.

Further, the panel were mindful of the medications that the NMC stated were missed in regard to this incident. It noted that in Witness 11's NMC witness statement dated 19 January 2025 she said:

> *'I have reviewed the safeguarding form and speaking with the unit leads that the [PRIVATE] was informed about the missed medication. However, no concerns were raised due to this,'*

However, the panel noted that some of the medications missed related to physical and/or psychological conditions with significant impacts on the residents' health if deterioration occurred.

It determined that as a Registered Nurse, notwithstanding the challenges at that time, you should know how to administer medication correctly and in a timely manner, that this was poor practice on your part and consequently amounted to misconduct.

In relation to Charge 3 and your failure to document the administration of medications on the MAR chart the panel noted all of the contextual factors as outlined for Charge 2. Additionally, it considered that you told the panel that you were sent home before you were able to transfer your notes from your pieces of paper into the MAR charts.

The panel determined that as Registered Nurse, part of your duty is to administer medication and record it in the appropriate place. The panel noted your admission in your oral evidence that your method of writing administered medications on a piece of paper to transfer later, was "*not best practice*". The panel further noted that Witness 3 in their oral testimony did not recall you writing on a piece of paper and there was no mention of this in Witness 9's evidence either. The panel determined that they could not be certain that this piece of paper even existed. Even if it did exist, the panel was of the view that partially recording the administration of medications was concerning and could lead to patient harm. The panel determined

that despite the context surrounding the incident in Charge 3, you had a duty as a Registered Nurse to fill in the MAR charts as you were going along in order to prevent any potential harm from occurring.

Therefore, the panel determined that, whilst there were [PRIVATE] on the date in question, you as a Registered Nurse had an obligation to ensure that the administration of medication was documented appropriately and thus does reach the threshold for a finding of misconduct.

In relation to Charge 11a, the panel noted your admission to his charge and your explanation that it was an oversight. The panel considered that the concerns found proved relate to a single incident and that there is no other evidence before it to suggest that it occurred on any other occasion. The panel considered that whilst missing a second signature on a controlled drug to be important, as you admitted to this charge. It noted that this appears to be a single incident with no other evidence to suggest that it has happened any other time. It was not presented with any evidence of a local controlled drug administration policy and that the MAR chart provides evidence of two separate signatures. As such it falls short of the threshold for a finding of misconduct.

In relation to Charge 11b, the panel noted your admission and considered your explanation in your written statement dated 29 October 2025 where you said:

> 'I *admit this charge to the extent that there was an administrative omission. However, my colleague and I did sign the MAR chart confirming administration.*'

The panel considered that this incident appears to have occurred on one occasion with no other evidence before it to suggest that it occurred more than once. The panel considered on the MAR chart of Resident D, under the date 10 March 2023, there appears to be your signature and one other. It determined that other colleagues would be aware that the Butec patch had been administered by viewing the MAR chart. The panel further noted the evidence of the Medication Policy, which gives a general overview of controlled drugs, but does not detail the handling of a

Butec patch nor where one is required to sign once the Butec patch has been administered. It determined that the concerns relating to Charge 11b are as a result of an administrative error and do not meet the threshold to reach a finding of misconduct.

In relation to Charge 11d, the panel noted the 10 March 2023 was the day you administered the Butec patch as evidenced by the MAR chart. As the panel was not presented with evidence detailing the specific appropriate steps to take when administering and checking a Butec patch on the day it was administered, the panel determined that this does not meet the threshold to reach a finding of misconduct.

The panel regards your failure to administer prescribed medication to elderly and highly vulnerable residents as a serious matter. The timely and correct administration and documentation of medication constitute a fundamental tenet of nursing practice, often representing the primary, and sometimes the only safeguard against uncontrolled pain, acute deterioration or life-threatening complications in frail individuals who are wholly dependent on others for their care and who in some cases lack the capacity to protect themselves.

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 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 and to maintain professional boundaries. 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/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) …

The panel concluded that limbs a) to c) of the *Grant* "test*"* were engaged in this case.

The panel considered the fundamental tenets of the nursing profession and considered that although there is evidence that you are able to practise kindly, your ability to practise safely and professionally falls below the professional standards expected of a Registered Nurse. The panel considered that in your recurring poor practice in administering medication over a twelve-month period, you put patients at risk of harm and there was also potential physical and emotional harm to patients and colleagues as a result of your misconduct. The panel considered that as a result of your poor practice in record keeping, another nurse could have administered a second dose of medication to a patient, and this not only put patients at risk of harm but put colleagues at risk of NMC proceedings themselves. The panel determined that your misconduct as demonstrated by your pattern of behaviour also brought the reputation of the nursing profession into disrepute. Together these shortcomings breach the fundamental tenants of the nursing profession. You did not prioritise people and you did not preserve safety. The public expects high standards of competence and professionalism from Registered Nurses, and your behaviour fell below these standards. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find such conduct to be serious.

The panel noted that you have been working competently as a Healthcare Assistant in the time since these allegations arose and was mindful of the challenge which you would have faced in securing employment during these proceedings. However, as you have been working as a Healthcare Assistant and not as a Registered Nurse, you have not been able to demonstrate to the panel's satisfaction that your poor practice in medicine administration and record keeping has been remediated.

Regarding insight, the panel considered your oral evidence at this hearing in relation to Charge 3. The panel considered that when you were asked why you documented information about the medications given on a piece of paper, you said, "*It's how we had worked on the previous shift, it was our strategy."* When asked when you would write the information on the piece of paper, you told the panel, "*As soon as we move*

from the patient, I would sit down at the end of the day with [Witness 3] to document everything."

During cross examination, you were asked if you accepted that some entries were not signed off, you said, "*We were working on a system, documenting it on a piece of paper*."

During panel questions you were asked how documenting on a piece of paper was more efficient that signing it on a MAR chart, you told the panel, *"Using the piece of paper seemed to work well, so we adopted this way. It was not appropriate but it was my way of working."* You were then asked if writing on a piece of paper was not appropriate and you told the panel, *"not appropriate but it did work for me."* You were then asked if you thought that it was good practice, you told the panel *"not good practice, in my own view it did not work on the second day."*

Taking this into consideration, the panel concluded that 30 October 2022 was not the only time that you have used this strategy, and you had used this strategy on a previous occasion. The panel noted that you only admitted that writing the administration of medication on a piece of paper was "*not good practice*" once probed during panel questions. This showed limited insight of the seriousness of not completing MAR charts at the time of medication administration. As a result of the pattern of behaviour and the limited insight, the panel determined there are no assurances that on a future occasion you would not repeat this pattern of behaviour and continue to adopt poor practice in recording the medications that you have administered.

The panel also considered your reflective statement and determined it did not include sufficient personal reflection on your role as a Registered Nurse. The panel found it to be formulaic and lacking meaningful insight, quoting general principles and focusing inward on what you have experienced. It did not take due consideration of the seriousness of your actions, nor demonstrate your understanding of the seriousness of your actions. Further, it did not address the impact that your actions may have had on your colleagues and patients and the nursing profession.

The panel was satisfied that the misconduct in this case is capable of being addressed.

The panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel considered that you have been working as a Healthcare Assistant in the time since the allegations arose. However, the panel recognised that you are unable to administer medication in your current role. Moreover, you have not yet been [PRIVATE] similar to those under which the original concerns in this case arose. Therefore, the panel were not satisfied that you would be able to administer medication safely and effectively if faced with the same [PRIVATE]. As a result, the panel determined that there is an ongoing risk of harm to patients in your care.

The panel noted your record of continuous professional development and the recent completed training courses namely '*Medication Administration'*, '*Medications Competency', 'Record Keeping', 'Duty of Care'* and '*Safeguarding Adults'*. The panel acknowledged your effort to maintain up-to-date knowledge and further your nursing practice. Further it noted that the courses chosen were focused and applicable to the areas of concern. However, noted that there is a gulf between the theory learnt in coursework and the stresses and realities of day-to-day practice. As you have been working as a Healthcare Assistant you have not be able to maintain your practice in administering medicine and keeping records of medicine administration and have not been tested under challenging circumstances.

Further, the panel considered your testimonials. They noted the testimonial from September 2025 from your Clinical Team Leader who has known you since 2018, which attests positively to your professionalism, practice and character. However, they noted your Clinical Team Lead could attest to you in your Healthcare Assistant role but was of limited use in attesting your current practice as a Registered Nurse as you have not been working in this type of role since these allegations arose.

The panel determined that whilst the matters of the charges found proved are remediable, they have not yet been remediated. The panel determined that there is a

definite risk of repetition, particularly in light of your continued lack of insight and insufficient remediation thus far.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel also 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 public expects high standards of competence and professionalism from Registered Nurses, and your behaviour fell below these standards. You did not prioritise people and you did not preserve safety, and you breached fundamental tenets of the nursing profession. An informed member of the public would be concerned about your conduct and public confidence in the profession and in the NMC as its regulator and the confidence of colleagues, would be undermined if a finding of impairment were not made. Therefore, the panel finds your fitness to practice also impaired on public interest grounds.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Mr Malik informed the panel that in the Notice of Hearing, dated 2 October 2025, 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. During the course of the hearing, the NMC revised its proposal and submits that a conditions of practice order for a period of 18 months is more appropriate and proportionate in light of the panel's findings.

Mr Malik referred to the panel to NMC guidance SAN-1 '*Factors to consider before deciding on sanctions'* last updated 2 December 2024.

Mr Malik took the panel through what he submitted were the aggravating factors of this case. He submitted that these were the potential for patient harm in terms of not providing medication, neglecting vulnerable residents and the repeated conduct in your failure to administer medications to more than one resident.

Mr Malik took the panel through what he submitted were some of the mitigating factors of this case. He submitted that these included [PRIVATE], possible staffing issues at the home in which you were working, and you were unfamiliar with the home processes. Mr Malik also submitted that there was no evidence of actual patient harm.

Mr Malik referred the panel to NMC guidance SAN-3a '*Taking no further action'* last updated 12 October 2018 and submitted that there are no exceptional features in this case that would warrant taking no further action and given the serious nature of the concerns, this would be insufficient in order to protect the public and maintain public confidence in the NMC as a regulator.

Mr Malik referred the panel to NMC guidance SAN-3b '*Caution order'* last updated 12 October 2018 and submitted that as there is no evidence that you have sufficiently remediated the concerns. He further submitted that there is still a risk of harm to patients, and a caution order would not be sufficient to protect the public or satisfy public interest considerations.

Mr Malik referred the panel to NMC guidance SAN-3c '*Conditions of practice order'* last updated 28 January 2020 and submitted that this is a sanction more suited to cases where there are clinical concerns and identifiable areas that the nurse can be supported to return to safe practice. He submitted that the concerns found proved in this case relate to your failing to administer medications and on record keeping. He submitted that these are clinical failings in this case and that further training could help address these concerns. Mr Malik submitted that there are conditions that would be workable and practicable to address the concerns found proved and adequately protect the public and the wider public interest, whilst addressing the deficiencies in your practice.

He submitted that in this case there is no evidence of any harmful deep-seated personality or attitudinal problems and there are identifiable areas of your practice in need of assessment and retraining, such as record keeping and medication administration. He submitted that there is no evidence of general incompetence and patients would not be put in danger, directly or indirectly if any conditions were imposed. He submitted that imposing a conditions of practice order would protect patients sufficiently during the period that they are enforced and that conditions can be created that allow you to be monitored and assessed. Mr Malik submitted that a conditions of practice order is the most appropriate in this case. Further, he submitted that a suspension or a strike-off order would be disproportionate in light of the facts found proved.

The panel also bore in mind Ms Curzon's submissions on your behalf.

Ms Curzon submitted that a conditions of practice order is the most appropriate and proportionate sanction in light of the panel's findings.

Ms Curzon took the panel through what she submitted were the mitigating factors in this case. She submitted that:

- You have provided a detailed reflective statement,
- [PRIVATE]
- Your misconduct occurred over three years ago,
- There has been no repetition of your misconduct,
- There was no harm to patients,
- You have undertaken relevant and targeted CPD in respect of the administration of medication, record keeping and duty of care,
- You have developing insight and have demonstrated some reflection on your failings.
- Positive references attesting to your ability to practise safely and competently as a Healthcare Assistant during the years since the charges,
- You have fully engaged in the NMC proceedings from the outset of the first referral, and you have no prior regulatory or subsequent regulatory history.

Ms Curzon invited the panel to recognise the steps that you have already taken and submitted that they are clearly a commitment to further development of your professional skills. She submitted that you have worked in the healthcare profession competently, professionally and safely as a Senior Healthcare Assistant. [PRIVATE]. Ms Curzon submitted that whilst [PRIVATE] is not determinative, it provides relevant context when assessing proportionality of any sanction.

Ms Curzon submitted that there is no evidence of harmful, deep-seated personality or attitudinal problems and that there are identifiable areas in need of assessment. She submitted that there is no evidence of general incompetence and that you have shown willingness and potential to respond positively to retraining. Further, she submitted that patients would not be put in danger as a result of the imposition of conditions and that there are conditions that would appropriately protect patients.

Ms Curzon submitted that you are committed to the nursing profession and addressing concerns by undertaking courses to further improve your practice. She submitted that you have already demonstrated a great deal of engagement in respect of these areas as evidenced by your targeted Certified Professional Coder (CPC) and continued work in the healthcare profession. Ms Curzon noted that in its determination, the panel could not be satisfied that your conduct was sufficiently remediated. Ms Curzon submitted that this is because you have been working as a Healthcare Assistant, who by virtue of your role have been unable to administer or record medication. She submitted that your current impairment cannot be fully addressed if you are not given the opportunity to work as a nurse whilst under conditions.

Ms Curzon reminded the panel that you have been subject to and have complied with an interim suspension order since the third referral, in a period of over two years and prior to this, you were subject to an interim conditions of practice order. She submitted that since the referrals were made, there has been limited opportunity for you to address the risks in your practise. She submitted that if the panel were minded to impose a conditions of practice order, it ensured that any conditions were relevant, proportionate and critically workable. She submitted that this was especially important as your previous conditions were restrictive in that you could not find employment as a nurse.

Ms Curzon submitted that it is in the public interest for a dedicated, committed and experienced nurse to be able to return to practice, albeit with the appropriate conditions in place. She submitted that a conditions of practice order would mark the seriousness of the misconduct and the importance of maintaining public confidence in the nursing profession. She submitted that it would also send the public and profession a clear message about the standards of practice required of a registered nurse. Further, Ms Curzon submitted that a conditions of practice order is a sanction that is also supported by the NMC.

Ms Curzon submitted that the concerns found proved can be adequately addressed by way of a conditions of practice order. She submitted that this would ensure that patients are kept safe in respect of any length of order. She submitted that six

months would be adequate particularly given the length of time since your misconduct took place and given the fact that you have already been on an interim conditions of practice order and subsequent interim suspension order for over two years.

Ms Curzon submitted that a suspension or strike-off order is not something that the NMC has submitted is appropriate. She submitted that the imposition of a suspension order would be disproportionate and not reasonable in the circumstances of your case. She submitted that a suspension order could be considered as punitive as it would prevent you from being able to address the concerns that the panel have identified.

The panel accepted the advice of the legal assessor

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 Sanction Guidance (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel considered the following aggravating features:

- Missed medication of elderly, frail and highly vulnerable patients
- Conduct which put patients at risk of suffering harm.
- Setting a poor example for fellow practitioners
- Lack of full insight into the seriousness of your failings
- Lack of full insight into your failings in that the potential of escalation was not recognised, resulting in ineffective management of the situation.

The panel also considered the following mitigating features:

- No previous concerns regarding medication administration,
- You have worked as Senior Healthcare Assistant since the allegations arose without any complaints against you,
- No evidence of actual patient harm,
- [PRIVATE],
- You have some developing insight into your failings,
- Positive references from your current employment,
- Reflective statement with limited insight,
- You have fully engaged in NMC proceedings,
- You have provided a record of your Continuous Professional Development (CPD) that is targeted towards the areas of concern namely 'Medication Administration', 'Record Keeping', 'Duty of Care'. These have been conducted over a period of time.

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 due to the continuing risk to patients. The panel considered that your conduct breached the fundamental tenets of the nursing profession and undermined the public trust in the nursing profession.

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 issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

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

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice. Although the nature of your misconduct is serious, it was reassured by your commitment to your professional development and positive testimonials about your ability to practise kindly in your role.

The panel had regard to the fact that these incidents happened three years ago and that, aside from these incidents, you have had an unblemished career as a nurse before and after these incidents. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

The panel balanced patient safety and the wider public interest against your own interest. The panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case as there has been no evidence to suggest that you have any deep-seated personality or attitudinal issues. Further, the panel considered that you have developing insight into your failings and there has been no evidence of a lack of competence. The panel noted that there has been no evidence of any repetition of concerns since the allegations against you arose. It further noted that this case is not so serious that it requires the temporary removal of you from nursing practice. The panel determined that to impose a suspension order or a striking-off order would not give you the opportunity to address your shortcomings and apply your learning in practice.

Having regard to the matters it has identified and that it is in the public interest for a dedicated, committed and experienced nurse to be able to return to practice, the panel concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

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

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

1. You must ensure that you are supervised any time you are working. Your supervision must consist of:
    - Working at all times on the same shift as, but not always directly observed by, a registered nurse of band 6 or above.

- Weekly meetings with a clinical line manager/ supervisor to discuss your clinical practice: administration of medication and controlled medication, record keeping and time management.

2. Within 2 months of commencing employment, you must send your case officer evidence that you have successfully completed a medication competency assessment to include controlled drugs which is recorded and signed by your assessor who is a Registered Nurse and countersigned by your Senior Manager.

3. You must undertake regular monthly supervisions with your clinical line manager/supervisor in order to routinely evaluate and discuss general clinical practice and concerns. This should be documented and sent to your case officer.

4. You must work with your clinical line manager/supervisor to create a personal development plan (PDP). Your PDP must address the concerns about current deficiencies in relation to:

    - Medication administration, including controlled drugs,
    - Record keeping,
    - Time management,
    - Concern escalation and any other deficiencies identified in ongoing practice.

Your PDP must set out actions to achieve objectives, provide timeframe of achievement and identify evidence of achievement within these timeframes. Your PDP must also include 4 monthly reflection which evidence your developing insight. You must send your case officer a copy of your PDP within 4 weeks of commencing regular employment, and regular updates every 4 months which show your progress towards achieving the aims set out in your PDP.

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

6. You must keep us informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

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

8. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

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

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Evidence of further training or coursework in:
    1. Medication Administration
    2. Record Keeping
    3. Appropriate escalation of concerns.

  A future panel may be further assisted by evidence of the context and content of these courses.

- Reflective statements evidencing improved insight into the risk of poor practice and the impact of poor practice on the safety of patients, on colleagues and on the reputation of the nursing profession.
- Testimonials from current employers evidencing current safe practice.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied

that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Malik. He submitted that given the panel's decision on sanction, a conditions of practice order for a period of 18 months is necessary in order to protect the public and is otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective.

Ms Curzon reminded the panel that that it can only make an interim order if it satisfied that it is necessary for the protection of the public and otherwise in the public interest, or your own interest. She submitted that imposing an interim order more serious than an interim conditions of practice order would be inconsistent with panel findings. She submitted that it would be a matter for panel.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to allow for the appeal period.
If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after you are sent the decision of this hearing in writing.

This will be confirmed to you in writing.

That concludes this determination.