Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 23 June – Thursday, 3 July 2025

Virtual Hearing

Name of Registrant:	**Samantha Leigh Jane Scanlon**
NMC PIN	94Y0315E
Part(s) of the register:	Registered Nurse – Adult Nursing RNA – (1 October 1997)
Relevant Location:	Derbyshire
Type of case:	Misconduct
Panel members:	Simon Banton (Chair, Lay member) Radica Hardyal (Registrant member) Delecia Dixon (Lay member)
Legal Assessor:	John Moir
Hearings Coordinator:	Nicola Nicolaou
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter
Mrs Scanlon:	Not present and not represented at the hearing
Facts proved:	Charges 1c, 1d, 1f, 5, 6a, 6b, 11a, 11b, 11c, 12a, 12c, 15, 24a, 24b, 26, and 28
Facts not proved:	Charges 1a, 1b, 1e, 2a, 2b, 3, 4a, 4b, 4c, 6c, 6d, 7a, 7b, 7c, 7d, 8a, 8b, 9a, 9b, 9c, 9d, 10a, 10b, 11d, 12b, 13, 14, 16, 17, 18a, 18b, 18c, 19a, 19b, 19c, 20a, 20b, 20c, 21, 22a, 22b, 23a, 23b, 25, 27, and 29
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (2 years)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Scanlon was not in attendance and that the Notice of Hearing letter had been sent to Mrs Scanlon's registered address by recorded delivery and by first class post on 7 May 2025.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mrs Scanlon's registered address on 8 May 2025. It was signed for against the printed name of 'Samantha L J Scanlon'.

Mr Malik, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Scanlon's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Scanlon has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Scanlon

The panel next considered whether it should proceed in the absence of Mrs Scanlon. It had regard to Rule 21 and heard the submissions of Mr Malik who invited the panel to continue in the absence of Mrs Scanlon. He submitted that Mrs Scanlon had voluntarily absented herself.

Mr Malik informed the panel that Mrs Scanlon sent an email to the NMC on 6 March 2025 stating that she did not want to cooperate or fill out any forms. She sent another email on 14 March 2025 indicating that she was prepared to participate and requested that the NMC send any information by post. Mr Malik submitted that there had been no further engagement by Mrs Scanlon with the NMC since 14 March 2025 and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Scanlon. In reaching this decision, the panel has considered the submissions of Mr Malik, the NMC's proceeding in absence bundle, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Scanlon;
- Mrs Scanlon has not engaged with the NMC since 14 March 2025;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020 – 2021;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and

- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Scanlon in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Mrs Scanlon at her registered address, she has made no response to the allegations. Mrs Scanlon will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Scanlon's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Scanlon. The panel will draw no adverse inference from Mrs Scanlon's absence in its findings of fact.

Details of charge (as amended)

That you, a registered nurse, in your role as Clinical Lead and/or Acting Home Manager at The Lodge Care Home:

1) Between June 2020 and 25 August 2021, in relation to one or more Resident, failed to ensure:
   a) care plans were completed adequately, or at all; **[NOT PROVED]**
   b) relevant clinical information was included within the care plans; **[NOT PROVED]**
   c) care plans were reviewed monthly as required; **[PROVED]**
   d) care plans were implemented and/or appropriate action taken in respect of Residents care, in a timely manner; **[PROVED]**
   e) risk assessments were conducted and/or documented in care plans; **[NOT PROVED]**

f) clinical information relating to catheter change for one or more Resident was documented adequately or at all; **[PROVED]**

2) Between 27 May 2021 and 28 May 2021, failed to update Resident A's care plan to accurately reflect their needs with respect to:
   a) catheter change; **[NOT PROVED]**
   b) bowel movement; **[NOT PROVED]**

3) On an unknown date, failed to ensure that Resident B's catheter was changed and/or document that the catheter had been changed; **[NOT PROVED]**

4) Between December 2020 and March 2021, in relation to Resident C's care plan:
   a) inaccurately discussed infection prevention and control in the hygiene section; **[NOT PROVED]**
   b) did not include steps that should be taken prior to administering Lorazepam; **[NOT PROVED]**
   c) failed to complete care plans on a monthly basis; **[NOT PROVED]**

5) On or around 24 June 2021 failed to ensure that Resident C's MAR chart specified the correct time to change their Transdermal patch; **[PROVED]**

6) Between November 2020 and December 2021, on one or more occasions failed to:
   a) ensure that Resident D's blood glucose levels were checked twice a day in accordance with their care plan; **[PROVED]**
   b) ensure that Patient D's blood sugar levels were checked twice a day; **[PROVED]**
   c) escalate and/or take appropriate action when Patient D's blood glucose readings were high; **[NOT PROVED]**
   d) escalate and/or take appropriate action when Resident D's blood glucose readings were low; **[NOT PROVED]**

7) Between 9 July 2021 and 11 July 2021:

a) on one or more occasions, gave Resident D, 20 units of insulin without checking their glucose levels; **[NOT PROVED]**
b) failed to keep a running total of Resident D's medication; **[NOT PROVED]**
c) failed to document when Resident D refused to take medication; **[NOT PROVED]**
d) failed to take appropriate action following Resident D's refusal to take medication; **[NOT PROVED]**

8) On or around 6 August 2021, in relation to Resident D, failed to:
   a) ensure that the correct number of Transdermal patches had been ordered; **[NOT PROVED]**
   b) ensure that 2 members of staff signed for medication received from the pharmacy; **[NOT PROVED]**

9) On or after 12 April 2020, failed to ensure that entries made in the controlled drug book, accounted for the following missing medication;
   a) 68 tablets prescribed to Resident E; **[NOT PROVED]**
   b) 11 tablets prescribed to Resident F; **[NOT PROVED]**
   c) 45 tablets prescribed to Resident G; **[NOT PROVED]**
   d) 69 tablets prescribed to Resident H; **[NOT PROVED]**

10) Between June 2021 and 9 July 2021, failed to ensure that staff:
   a) had documented the date Resident H's Lansoprazole box was opened; **[NOT PROVED]**
   b) kept a running total of Lansoprazole; **[NOT PROVED]**

11) Between 30 April 2020 and 12 May 2020, having administered Midazolam to the following Residents, failed to ensure that the amount of Midazolam left in open ampules, was discarded:
   a) Resident I; **[PROVED]**
   b) Resident J; **[PROVED]**
   c) Resident K; **[PROVED]**
   d) Resident L; **[NOT PROVED]**

12) Between July 2021 and September 2021 in relation to Resident O blood glucose monitoring form, failed to:
    a) document an upper and/or lower reading; **[PROVED]**
    b) ensure that blood level readings were recorded; **[NOT PROVED]**
    c) ensure that the form was signed; **[PROVED]**

13) On or around 24 June 2021, failed to change Resident P's catheter within 48 hours of their admission at the Home; **[NOT PROVED]**

14) On 1 July 2021, failed to change Resident P's catheter as documented on their catheter chart; **[NOT PROVED]**

15) On one or more occasion, failed to ensure that one or more Residents full name was recorded on controlled drug book entries; **[PROVED]**

16) On 12 July 2021, administered 9mg of Warfarin to Resident Q which was the incorrect dose and/or failed to document accurately; **[NOT PROVED]**

17) On 31 July 2021 failed to administer and/or document that you had administered Warfarin to Resident Q; **[NOT PROVED]**

18) On or around 23 July 2021, on Resident R's MAR chart, failed to:
    a) document the balance for Baclofen liquid; **[NOT PROVED]**
    b) keep a running total of the medication after each administration; **[NOT PROVED]**
    c) document when medication was not administered; **[NOT PROVED]**

19) On or around July 2021, on Resident S's MAR chart, failed to:
    a) document the running total of one or more medication; **[NOT PROVED]**
    b) document when medication was not administered; **[NOT PROVED]**
    c) write in block capitals to ensure that the writing was legible; **[NOT PROVED]**

20) On or around July 2021, in relation to Resident T, failed to document a running total of medication stock for the following medication:

a) Adcal D3 tablets; **[NOT PROVED]**
b) Fludrocortisone; **[NOT PROVED]**
c) Lactulose; **[NOT PROVED]**

21) On or around 9 July 2021, in relation to Resident U, failed to document the running total of Docusate following administration; **[NOT PROVED]**

22) On or around 9 July 2021, in relation to Resident V, failed to:
a) document the running total of Docusate tablets following administration; **[NOT PROVED]**
b) document the number of Docusate tablets administered; **[NOT PROVED]**

23) On an unknown date in February 2021, failed to investigate and/or escalate concerns that Colleague A:
a) had touched one or more female Resident inappropriately in a previous employment, resulting in dismissal; **[NOT PROVED]**
b) was in an inappropriate relationship with a Resident at the Home; **[NOT PROVED]**

24) Between April 2021 and July 2021, on one or more occasions, failed to ensure audits were completed accurately in that you wrongly documented that there had been:
a) over 90% compliance in one or more medication audit; **[PROVED]**
b) over 90% compliance in one or more care plan audit; **[PROVED]**

25) On 6 July 2021, signed off an audit completed by a Colleague as correct when it was not; **[NOT PROVED]**

26) On 7 July 2021, signed off an infection control audit as accurate when it was not; **[PROVED]**

27) Failed to identify and/or ensure, on one or more occasions, that Continuing Healthcare Checklist Assessments were completed for those Residents that qualified for additional funding; **[NOT PROVED]**

28) Between April 2021 and August 2021 on one or more occasions failed, without justification, to follow management request to complete CHC assessments; **[PROVED]**

29) On or around July 2021, failed to ensure that medication kept in the fridge was appropriately labelled to indicate when it had been opened; **[NOT PROVED]**

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

Background

Mrs Scanlon was referred to the NMC on 20 September 2021 by Witness 1, Clinical Area Manager, Select Healthcare ('the Company').

At the time of the concerns raised in the referral, Mrs Scanlon was employed as a Clinical Lead, and the Deputy Home Manager at The Lodge Care Home ('the Home'). Additionally, from part of a period of concern, Mrs Scanlon was also the acting Home Manager. The concerns raised in the referral came to light when Witness 1 attended the Home to provide support whilst Mrs Scanlon was on annual leave. Witness 1 reviewed all of the Home's audits for the previous four months against the record that could have been reviewed as part of the audit. Witness 1 identified numerous issues at the Home relating to things such as care plans, risk assessments, medication practises, the escalation of incidents and concerns, and other matters.

An internal investigation was commenced and Mrs Scanlon was suspended on 9 August 2021. Mrs Scanlon was subsequently dismissed from her role following a disciplinary meeting on 6 September 2021.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Malik, on behalf of the NMC, to amend the wording of charges 4 and 7d. Mr Malik also suggested an amendment to the introduction of the charges:

> ‘That you, a registered nurse, in your role as Clinical Lead and/or Acting Home Manager **at The Lodge Care Home**:’

Charge 4

> 4) Between December ~~2021~~ **2020** and March 2021, in relation to Resident C’s care plan:

Charge 7d

> 7) Between 9 July 2021 and 11 July 2021:
>
> …
>
> d) failed to take appropriate **action** following Resident D’s refusal to take medication;

It was submitted by Mr Malik that the proposed amendments would provide clarity and more accurately reflect the evidence.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Scanlon and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

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

Prior to making submissions on the hearsay application, Mr Malik made a request that the hearsay application be held in private on the basis that there will be reference to [PRIVATE]. The application was made pursuant to Rule 19.

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

Having heard that there will be reference to [PRIVATE], the panel determined to hold the entirety of the hearsay application in private in order to protect Witness 2's privacy.

Decision and reasons on application to admit the written statement and accompanying documentation of Witness 2

[PRIVATE]

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement and accompanying documentation of Witness 2, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

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.

The panel has drawn no adverse inference from the non-attendance of Mrs Scanlon.

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

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

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

- Witness 1: Clinical Area Manager for the Company

- Witness 3: Area Manager for the Company

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 Mrs Scanlon.

The panel first considered the Witness statement of Witness 2 which outlined the responsibilities of Ms Scanlon in her role as Clinical Lead at the Home:

> *'*[…] *As the Clinical Lead, Ms Scanlon was in charge of all clinical governance expected under the CQC* [Care Quality Commission] *regulations and responsible for the overall governance of resident's care. The responsibilities of the Clinical Lead include medication management, audits, and leading the team of nurses, including completing appraisals and ensuring competencies continue to be met by nursing staff.* […]*'*

The panel also took into account the case of *Dutta v GMC* [2020] EWHC 1974 Admin and noted that it is not always possible to rely on the recollection of an eyewitness. Relying solely on the evidence of eyewitness recollection is notoriously unreliable after passage of time. The panel considered that there is no suggestion that any of the witnesses in this case were not credible in the sense of deliberately trying to mislead, however, there are concerns surrounding the reliability of their

evidence when the witnesses were not able to refer the panel to supporting contemporaneous documentation.

As such, in the absence of contemporaneous documentation, the reliability of the evidence needs to be assessed separately in relation to each charge.

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

Charges 1a and 1b

1) Between June 2020 and 25 August 2021, in relation to one or more Resident, failed to ensure:

    a) care plans were completed adequately, or at all;
    b) relevant clinical information was included within the care plans;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident C's care plan and considered that it only had parts three and seven of the care plan before it. The panel noted that whilst the parts of the care plan that it had sight of appears to be adequate, as they are clearly detailed and are specific to Resident C, without the care plan in its entirety, the panel cannot be satisfied that the care plans were not completed adequately, or at all.

The panel determined that the NMC have not satisfied their evidential burden in relation to this charge and therefore found this charge not proved.

Charge 1c

1) Between June 2020 and 25 August 2021, in relation to one or more Resident, failed to ensure:

c) care plans were reviewed monthly as required;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated that:

> *'*[…] *The photocopy of this care plan was taken in August 2021 indicating that no reviews were conducted in June and July 2021.* […]*'*

The panel noted in Resident C's care plan that there were monthly reviews conducted from 21 January 2021 until 19 May 2021, but not thereafter. It considered that there was no indication on the care plan that Resident C's status had changed, in that they either moved to another care home, or had passed away. From this, the panel inferred that for the months of June and July 2021, Resident C had still been a resident at the Home, but that their care plan was not reviewed.

The panel also considered Mrs Scanlon's own statement dated 5 September 2021 which stated:

> *'*[…] *I have been concerned for over a year that certain things were falling by the wayside (including medicines management and care planning) because my workload and 'duties' had increased to such a seemingly impossible level that I was unable to keep up* […]*.'*

The panel therefore found this charge proved on the balance of probabilities.

Charge 1d

1) Between June 2020 and 25 August 2021, in relation to one or more Resident, failed to ensure:

d) care plans were implemented and/or appropriate action taken in respect of Residents care, in a timely manner;

This charge is found proved.

In reaching this decision, the panel took into account Resident C's care plan. It noted that the care plan was initiated on 6 December 2020 which provided an identified need regarding cognition and psychological issues. The panel noted that the care plan was not updated until 11 March 2021, some three months later, which described how Resident C might receive Lorazepam. The panel determined that this was not a timely response to Resident C's evident health conditions.

Further, the panel noted that a DOLS (Deprivation of Liberty Safeguards) form had been completed for Resident C on 8 January 2021. The panel reminded itself that the care plan for Resident C had been reviewed on 21 January 2021, two weeks later, and the review stated 'care plan remains effective, relevant, and unchanged' despite the information contained within the DOLS form.

The panel therefore found this charge proved.

Charge 1e

1) Between June 2020 and 25 August 2021, in relation to one or more Resident, failed to ensure:

    e) risk assessments were conducted and/or documented in care plans;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> *'When reviewing resident's records, I noticed that there were no risk assessments in place. As they were not in place I am unable to provide any documentation to demonstrate this issue.* […] *There was an issue within the*

Home in that the archiving of paper records was poor meaning that it was very difficult to locate documents. […]*'*

The panel also took into account Witness 3's oral evidence when she said that *"homes were visited at least monthly as part of audit and oversight."* The panel considered that it would have expect this to have been raised earlier if it was Mrs Scanlon's duty to ensure that risk assessments were conducted and/or documented in care plans.

The panel further took into account Mrs Scanlon's own statement dated 5 September 2021 which stated:

'[…] *I did inform* [previous manager] *on many occasions however that although I had started care plans and completed the initial risk assessments and then passed them to other nurses to evaluate and add to, that this was not being done.* […] *I should also mention that the managers desk when I took over was chaotic and disorganised with piles of paperwork in no logical order and I was unable to find certain important documents, and getting complaints from staff that they had given her completed forms that were now nowhere to be seen'*

The panel inferred that this was an indication that Mrs Scanlon was completing risk assessments and therefore found this charge not proved on the balance of probabilities.

Charge 1f

1) Between June 2020 and 25 August 2021, in relation to one or more Resident, failed to ensure:

    f) clinical information relating to catheter change for one or more Resident was documented adequately or at all;

This charge is found proved.

In reaching this decision, the panel took into account Resident P's indwelling catheter chart dated 24 June 2021 where entries were made regarding the catheter for Resident P.

The panel accepted Witness 1's recommendations for catheter best practice in her witness statement and noted that Resident P's indwelling catheter chart dated 24 June 2021 did not conform to that. As such, the panel found that the documentation regarding the catheter for Resident P was inadequate.

The panel therefore found this charge proved.

Charge 2a

2) Between 27 May 2021 and 28 May 2021, failed to update Resident A's care plan to accurately reflect their needs with respect to:

   a) catheter change;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> '[…] *I checked the care plan and there was nothing relating to a catheter change in there. I have been unable to locate a copy of this care plan due to a number of records going missing at the Home after Ms Scanlon left.* […]'

The panel also had sight of the Home Investigation Report but noted that this had not been dated or signed and therefore attached limited evidential weight to this.

The panel was dependent on the witness statement of Witness 1 as there is no contemporaneous documentation to support it. The panel noted that there are concerns about the validity of the documentation that has been provided to the NMC.

In the absence of Resident A's care plan, the panel attached limited evidential weight to Witness 1's witness statement in relation to this charge.

The panel cannot be satisfied that the NMC have met its evidential burden and therefore determined that this charge is not proved.

Charge 2b

2) Between 27 May 2021 and 28 May 2021, failed to update Resident A's care plan to accurately reflect their needs with respect to:

   b) bowel movement;

This charge is found NOT proved.

In reaching this decision, the panel considered that it does not have sight of Resident A's care plan and therefore cannot determine whether records in relation to Resident A's bowel movement was absent from the care plan.

The panel further noted that the Home Investigation Report does not mention bowel movement but attached limited evidential weight to this due to it not being dated or signed.

The panel was dependent on the witness statement of Witness 1 as there is no contemporaneous documentation to support it. In the absence of Resident A's care plan, the panel attached limited evidential weight to Witness 1's witness statement in relation to this charge.

The panel cannot be satisfied that the NMC have satisfied their evidential burden and therefore determined that this charge is not proved.

Charge 3

3) On an unknown date, failed to ensure that Resident B's catheter was changed and/or document that the catheter had been changed;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> *'I was also concerned that Resident B's* […] *catheter did not appear to have been changed during his stay at the Home.* […] *I looked in the clinical diary to see whether a change had been recorded there but it had not.* […] *I spoke to Ms Scanlon about this incident on the day that I suspended her in early August 2021. She told me that it had been changed and that it was recorded on the handover document however, she was unable to locate the relevant handover document.'*

The panel noted that it does not have any contemporaneous documentation before it, such as Resident B's care plan, or the clinical diary.

The panel was dependent of the Witness statement of Witness 1 as there is no contemporaneous documentation to support this. The panel attached limited evidential weight to Witness 1's statement in relation to this charge.

The panel determined that the NMC has not brought sufficient evidence to support on the balance of probabilities that this charge is proved.

Charge 4a

4) Between December 2020 and March 2021, in relation to Resident C's care plan:

   a) inaccurately discussed infection prevention and control in the hygiene section;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> '[…] *This care plan was written by Ms Scanlon and I know this as she has signed it. It is inadequate as it discusses infection prevention and control but this should not be discussed in the hygiene and dressing care plan and instead, should be in a separate infection prevention and control care plan.* […]'

The panel considered that Resident C's care plan did discuss infection prevention and control. Although this was not where Mrs Scanlon was expected to document it, the panel was satisfied that it was documented. Moreover, only parts of Resident C's care plan were before the panel and it was therefore not possible to confirm that the entry was made in the wrong part, or if there was another part of the care plan in which it should have been noted.

The panel further considered that Resident C's care plan does not appear to have pre-determined sections contained within it that need to be filled in.

The panel therefore determined that on the balance of probabilities, this charge is not proved.

Charge 4b

4) Between December 2020 and March 2021, in relation to Resident C's care plan:

   b) did not include steps that should be taken prior to administering Lorazepam;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> *'*[…] *The care plan says that Lorazepam should be administered if all else fails but it does not outline what steps should be taken prior to administering Lorazepam.* […]*'*

The panel considered that it is not clear what the steps should have been prior to administering Lorazepam. It took into account Resident C's care plan which states, *'see print out'* and acknowledged that it was acceptable practice to signpost to another document that may outline details, however, the panel does not have this print out before it. The panel also did not have the Home's medication policy before it.

The panel was dependent of the Witness statement of Witness 1 as there is no contemporaneous documentation to support this. The panel attached limited evidential weight to Witness 1's statement in relation to this charge.

The panel cannot be satisfied based on the evidence before it that the NMC has met its evidential burden in relation to this charge. Therefore, on the balance of probabilities, this charge is found not proved.

Charge 4c

4) Between December 2020 and March 2021, in relation to Resident C's care plan:

   c) failed to complete care plans on a monthly basis;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident C's care plan. It noted that the last entry indicating a review of the care plan was 19 May 2021. The panel considered that there was an indication of a failure to complete care plans on a

monthly basis for the months following May 2021, however, the charge only speaks to the time period of December 2020 to March 2021.

The panel was therefore satisfied that monthly reviews of Resident C's care plan were conducted between December 2020 and March 2021.

Charge 5

5) On or around 24 June 2021 failed to ensure that Resident C's MAR chart specified the correct time to change their Transdermal patch;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> *'*[…] *Resident C was prescribed a transdermal patch to be given once per week. Someone has written on the chart that it should be administered at breakfast. A patch should be applied at the same time each time it is changed.* […]*'*

The panel accepted that it was good nursing practise to specify the time that the transdermal patch was changed, and that on Resident C's MAR (Medication Administration Record) chart, stating 'breakfast' only, and not a specific time, was not adequate as 'breakfast' was open to wide interpretation.

The panel therefore found this charge proved on the balance of probabilities.

Charges 6a and 6b

6) Between November 2020 and December 2021, on one or more occasions failed to:

a) ensure that Resident D's blood glucose levels were checked twice a day in accordance with their care plan;
b) ensure that Patient D's blood sugar levels were checked twice a day;

This charge is found proved.

In reaching this decision, the panel firstly considered that Resident D and Patient D is the same person. The panel considered both charges together due to the similarity of the charges, and the supporting evidence provided.

The panel took into account Resident D's blood glucose monitoring form for the period of November 2020 to September 2021. The panel noticed that on 31 May 2021, 1, 18, 19, and 20 June 2021, there are no time entries of blood glucose levels being checked, and no record of tests being refused by Resident D.

The panel therefore found these charges proved on the balance of probabilities. Given the apparent duplication of charges 6a and 6b, the panel determined that at the misconduct stage, it would only consider misconduct for charge 6a.

Charges 6c and 6d

6) Between November 2020 and December 2021, on one or more occasions failed to:

c) escalate and/or take appropriate action when Patient D's blood glucose readings were high;
d) escalate and/or take appropriate action when Resident D's blood glucose readings were low;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident D's blood glucose monitoring form for the period of November 2020 to September 2021. It considered that whilst the form does indicate high and low readings, it is not clear what the

protocol was on receiving these high/low readings. The panel further noted that there is no area on the form to document an action taken if there were concerns of a high/low blood glucose reading.

The panel was not satisfied that the NMC have met the evidential burden for these charges and therefore found these charges not proved on the balance of probabilities.

Charge 7a

7) Between 9 July 2021 and 11 July 2021:

a) on one or more occasions, gave Resident D, 20 units of insulin without checking their glucose levels;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident D's insulin chart dated 9 July 2021. The panel noted that the chart shows insulin being given to Resident D on 9 and 11 July 2021, despite their blood glucose not being tested. However, the panel also took into account Resident D's blood glucose monitoring form for the period of November 2020 to September 2021 and acknowledged that Resident D refused blood glucose testing on 9 and 11 July 2021.

The panel further considered that the signatures on the insulin chart for the dates of 9 and 11 July 2021 are different. The panel could not be satisfied that Mrs Scanlon signed the insulin administration on either of these dates as the signatures do not match her signature as seen on other documents, such as Resident C's care plan. The panel noted that this charge related to a direct duty of Mrs Scanlon. It was not satisfied that she had a direct duty to check Resident D's blood glucose levels as she was not present at the administration.

The panel therefore found this charge not proved on the balance of probabilities.

Charge 7b

7) Between 9 July 2021 and 11 July 2021:

    b) failed to keep a running total of Resident D's medication;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident D's insulin chart dated 9 July 2021 and noted that it was the responsibility of the nurse administering the medication to have maintained a running total of said medication. The panel considered that from the signatures on 9 and 11 July 2021, these do not appear to belong to Mrs Scanlon as seen in other documents. For this reason, the panel determined that it was not Mrs Scanlon's responsibility to keep a running total of Resident D's medication, as she did not administer it to Resident D.

The panel therefore found this charge not proved on the balance of probabilities.

Charge 7c

7) Between 9 July 2021 and 11 July 2021:

    c) failed to document when Resident D refused to take medication;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident D's MAR chart dated 9 July 2021 and noted there is a medication chart which is completely blank and therefore has no indication of any residents or dates that are applicable to this charge.

The panel considered that there is no space on Resident D's MAR chart to record additional information regarding their refusal to take their medication. The panel further considered that there is no evidence before it to suggest that Mrs Scanlon

was responsible for the immediate documentation of when residents refused to take their medication.

The panel therefore found this charge not proved on the balance of probabilities.

Charge 7d

7) Between 9 July 2021 and 11 July 2021:

    d) failed to take appropriate action following Resident D's refusal to take medication;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> '[…] *He* [Resident D] *is also refusing Laxido and Docusate regularly.* […]'

The panel also took into account Resident D's MAR chart dated 9 July 2021 which states that Resident D refused Docusate, Furosemide, Laxido, Metformin, and Prednisolone on 9 July 2021, and he also refused Laxido on 11 July 2021.

The panel considered that there is no evidence before it to suggest that Mrs Scanlon did or did not take appropriate action following Resident D's refusal to take medication. In the absence of the Home's policies regarding Resident D's refusal of medications, the panel attached little evidential weight to Witness 1's witness statement in relation to this charge.

The panel therefore determined that the NMC have not satisfied their evidential burden for this charge and therefore found this charge not proved on the balance of probabilities.

Charges 8a and 8b

8) On or around 6 August 2021, in relation to Resident D, failed to:

a) ensure that the correct number of Transdermal patches had been ordered;
b) ensure that 2 members of staff signed for medication received from the pharmacy;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> '[…] *Ms Scanlon went on annual leave for 2 weeks (from 26 July – 9 August 2021)'*

The panel also took into account Resident D's medication profile dated 6 August 2021 which indicates that an incorrect number of transdermal patches were ordered, and that less than two members of staff signed for the medication received by the pharmacy. However, the panel noted that the charges refer to a period when Mrs Scanlon was on annual leave, and therefore could not be responsible for ensuring that this was conducted.

The panel further noted that Mrs Scanlon returned from annual leave on 9 August 2021 and was subsequently suspended from her role on 11 August 2021, therefore, she was not likely to have conducted checks in the two days she was back at work before being suspended.

The panel therefore found these charges not proved on the balance of probabilities.

Charges 9a, 9b, 9c, and 9d

9) On or after 12 April 2020, failed to ensure that entries made in the controlled drug book, accounted for the following missing medication;

a) 68 tablets prescribed to Resident E;
b) 11 tablets prescribed to Resident F;
c) 45 tablets prescribed to Resident G;
d) 69 tablets prescribed to Resident H;

This charge is found NOT proved.

In reaching this decision, the panel examined the controlled drug books for Residents E, F, G, and H and noted discrepancies in the entries. The panel further noted that the controlled drug destruction book, which was referred to in evidence, was not before it.

The panel cannot be satisfied that the scan of the purported controlled drug book for Resident E sufficiently proves that the entries were taken from a controlled drug register. This scan is only partially captured and details have been cropped.

Regarding the purported controlled drug book for Resident F, there is no record of what the missing drug is. This scan is only partially captured and details have been cropped.

The controlled drug books for Residents G and H record the drugs being referred to, and both refer that these drugs were no longer being stored in the controlled drug trolley or cupboard.

The panel considered that it had not had sight of the medication policy, as referred to in Witness 1's witness statement:

> '[…] *Ms Scanlon should also have been checking all of the CD* [Controlled Drug] *books herself on a weekly basis for any errors. CD checks should also be carried out daily (from shift to shift) by the member of staff on shift with the medication keys and this was a part of the Home's medication policy. These policies are overwritten when a new version comes into force and I am therefore unable to provide a copy of the version of the policy in place at the time of the incident.* […]'

The panel also took into account Mrs Scanlon's local statement written at the time of the investigation dated 5 September 2021 which stated:

> *'*[…] *we were expected to put all pregabalin and gabapentin in the CD book and cupboard (which is very small) and 2 nurses were expected to sign them out each time, there are alot* [sic] *of residents on this medication more than once or even twice a day in some cases, this proved to be extremely time consuming and was having a knock on effect with other nursing duties.* […] *We then had a meeting with Quantum expressing our concerns, it was then that they back tracked and stated that we no longer needed to put them in the CD book and check them out as long as they were locked up in the medicines trolley and counted at each administration. We therefore discontinued writing in the CD book.* […]*'*

The panel considered that, in the absence of contemporaneous documents such as prescription records or MAR charts for Residents E, F, G, and H, it could attach little weight to Witness 1's witness statement relating solely to her recollection.

The panel considered that it cannot be determined whether the drugs were continued to be administered to the residents despite no longer being recorded in the controlled drug book. The panel therefore found this charge not proved on the balance of probabilities.

Charge 10a

> 10) Between June 2021 and 9 July 2021, failed to ensure that staff:
>
> a) had documented the date Resident H's Lansoprazole box was opened;

This charge is found NOT proved.

In reaching this decision, the panel took into account the image of the Lansoprazole box contained within the evidence bundle. The panel considered that it had not been

provided with images of all surfaces of the box, and therefore could not determine whether or not Mrs Scanlon ensured that staff had documented on it, the date that Resident H's Lansoprazole box was opened.

The panel therefore found this charge not proved on the balance of probabilities.

Charge 10b

10) Between June 2021 and 9 July 2021, failed to ensure that staff:

b) kept a running total of Lansoprazole;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident H's MAR chart dated 9 July 2021 and noted that the dates specified within the charges are not the same dates contained on the page of the MAR chart provided. The MAR chart only covers from 9 July 2021, from which date onwards there is a running total of Lansoprazole documented.

The panel was not satisfied that the NMC have met its evidential burden in relation to this charge. The panel therefore found this charge not proved on the balance of probabilities.

Charges 11a, 11b, and 11c

11) Between 30 April 2020 and 12 May 2020, having administered Midazolam to the following Residents, failed to ensure that the amount of Midazolam left in open ampules, was discarded:

a) Resident I;
b) Resident J;
c) Resident K;

This charge is found proved.

In reaching this decision, the panel took into account Resident I's controlled drug book dated April, May, and June 2020, Resident J's controlled drug book dated May, July, and August 2020, and Resident K's controlled drug book from various dates in May 2020.

The panel considered that it is not clear for all instances when open ampules were discarded. It considered that it was Mrs Scanlon's responsibility to ensure that these ampules were discarded appropriately.

The panel also took into account Mrs Scanlon's own statement dated 5 September 2021 which stated:

> *'*[…] *Sometimes we were afraid that we would run out of a medication needed for a resident that would be in a great deal of discomfort and distress without it so in order to avoid this we felt it necessary to try to save doses from the same vial pending the arrival of the items required.* […]*'*

Within Resident K's controlled drug book from various dates in May 2020, it is stated on 12 May 2020 *'ampuole* [sic] *saved for further doses*.'

The panel considered that there was some evidence before it to suggest that there were partial doses of Midazolam remaining in the quantity left, which is indicative of an open ampule being saved.

The panel therefore found this charge proved on the balance of probabilities

Charge 11d

11) Between 30 April 2020 and 12 May 2020, having administered Midazolam to the following Residents, failed to ensure that the amount of Midazolam left in open ampules, was discarded:

d) Resident L;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident L's controlled drug book from various dated in June 2021. The panel noted that the dates specified in the charge are between 30 April and 12 May 2020, however the dates within Resident L's controlled drug book only cover 13 and 14 June 2020, and therefore does not support this charge.

The panel therefore found this charge not proved.

Charge 12a

12) Between July 2021 and September 2021 in relation to Resident O blood glucose monitoring form, failed to:

a) document an upper and/or lower reading;

This charge is found proved.

In reaching this decision, the panel took into account Resident O's blood glucose monitoring form dated July – September 2021. The panel considered that it is evident from this form that the acceptable upper and/or lower readings are not specified.

The panel was satisfied that an assurance check of this was Mrs Scanlon's responsibility as part of her routine duties. This is evidenced in Witness 1's witness statement which stated:

> '[…] *There is no acceptable lower and upper reading recorded on the form for this resident. This form is missing signatures and on some occasions a reading has not been recorded at all. I would also have expected Ms Scanlon to have picked up on this as part of the care documentation audit and as*

stipulated above, she should have been checking these charts at the end of every shift to ensure that residents' nutritional needs were being met.'

The panel therefore found this charge proved on the balance of probabilities.

Charge 12b

12) Between July 2021 and September 2021 in relation to Resident O blood glucose monitoring form, failed to:

b) ensure that blood level readings were recorded;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident O's blood glucose monitoring form dated July – September 2021. The panel noted that the form records full entries for the periods specified in the charge during the period in which Mrs Scanlon was still working prior to her annual leave from 26 July – 9 August 2021, and subsequent suspension on 11 August 2021.

The panel therefore found this charge not proved.

Charge 12c

12) Between July 2021 and September 2021 in relation to Resident O blood glucose monitoring form, failed to:

c) ensure that the form was signed;

This charge is found proved.

In reaching this decision, the panel took into account Resident O's blood glucose monitoring form dated July – September 2021. The panel considered that there is evidence of one entry on 23 July 2021 that was not signed.

The panel therefore found this charge proved on the balance of probabilities.

Charge 13

13) On or around 24 June 2021, failed to change Resident P's catheter within 48 hours of their admission at the Home;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> *'*[…] *Ms Scanlon was responsible for ensuring that the resident's catheter was changed within 48 hours of admission.* […]*'*

The panel considered that it was not specified that it was Mrs Scanlon's responsibility to change Resident P's catheter herself.

The panel also took into account Resident P's indwelling catheter chart dated 24 June 2021 and noted that Mrs Scanlon did not admit Resident P into the Home, and therefore it was not her responsibility at that point to change their catheter.

The panel therefore found this charge not proved.

Charge 14

14) On 1 July 2021, failed to change Resident P's catheter as documented on their catheter chart;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident P's indwelling catheter chart dated 24 June 2021 which stated that the catheter needed to be changed on 1 July 2021.

The panel also took into account Witness 1's witness statement which stated:

> *'*[…] *The catheter was not changed on 1 July 2021 and was changed by me on 12 August 2021 when I picked up on the concern.* […]*'*

The panel referred back to its previous finding that it was not Mrs Scanlon's duty to change the catheter herself, and therefore determined that it was not her responsibility to contemporaneously document that it had been changed on the catheter chart.

The panel found this charge not proved.

Charge 15

15) On one or more occasion, failed to ensure that one or more Residents full name was recorded on controlled drug book entries;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> *'*[…] *Ms Scanlon has written the resident's name on her entry as Resident K but it should be the resident's full original name that is recorded.* […] *It is important to record residents' full names in the CD book'*

The panel also took into account Resident K's controlled drug book from various dates in May 2020 and noted that Resident K's name was not recorded in column six of the book with the heading *'Name of Patient (Healthcare professional's name and address if collecting)'*.

Due to the redaction in the controlled drug book, the panel could not see the original notation, nor was it aware of Resident K's full name. However, the panel accepted the evidence of Witness 1 that the resident's full name was necessary and that it was not Resident K's full name included in column six of the controlled drug book.

The panel therefore found this charge proved.

Charge 16

16) On 12 July 2021, administered 9mg of Warfarin to Resident Q which was the incorrect dose and/or failed to document accurately;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident Q's Warfarin chart dated 9 July 2021 and noted that the signature on the chart does not match Mrs Scanlon's signature in other documents such as Resident C's care plan. The panel was not satisfied that Mrs Scanlon had a direct duty to administer the drug on this date.

The panel therefore found this charge not proved.

Charge 17

17) On 31 July 2021 failed to administer and/or document that you had administered Warfarin to Resident Q;

This charge is found NOT proved.

In reaching this decision, the panel considered that Mrs Scanlon was on annual leave on 31 July 2021 and therefore would not have administered or documented the administration of Warfarin to Resident Q.

Further, the panel previously identified that it was not Mrs Scanlon's responsibility to administer or document the administration of medication to Resident Q on this occasion.

The panel therefore found this charge not proved.

Charges 18a, 18b, and 18c

18) On or around 23 July 2021, on Resident R's MAR chart, failed to:

a) document the balance for Baclofen liquid;
b) keep a running total of the medication after each administration;
c) document when medication was not administered;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident R's MAR chart dated 23 July 2021 and noted that the signature for Baclofen administration on 23 July 2023 does not match Mrs Scanlon's signature as seen in other documents such as Resident C's care plan. The panel therefore inferred that Mrs Scanlon did not administer Baclofen to Resident R on this date.

As specified by the charge, it was not Mrs Scanlon's responsibility to document the balance for Baclofen liquid, keep a running total of the medication after each administration, or document when the medication was not administered.

Further, the panel noted that the MAR chart does not show any omission of administration of the medication on 23 July 2021, as alleged in charge 18c.

The panel therefore found these charges not proved.

Charges 19a, 19b, and 19c

19) On or around July 2021, on Resident S's MAR chart, failed to:

a) document the running total of one or more medication;
b) document when medication was not administered;
c) write in block capitals to ensure that the writing was legible;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident S's MAR chart dated 21 July 2021 and noted that the signature for the medication does not match Mrs Scanlon's signature as seen in other documents such as Resident C's care plan. The panel therefore inferred that Mrs Scanlon did not administer the medication on or around July 2021.

The panel further noted that Docusate was signed for by 'S.S' on 6, 7, 14, and 15 August 2021, however it took into account Witness 1's witness statement which confirmed that Mrs Scanlon returned from annual leave on 9 August 2021 and was suspended on 11 August 2021, therefore, the panel determined that the signatures could not belong to Mrs Scanlon.

The panel therefore found this charge not proved on the balance of probabilities.

Charges 20a, 20b, and 20c

20) On or around July 2021, in relation to Resident T, failed to document a running total of medication stock for the following medication:

a) Adcal D3 tablets;
b) Fludrocortisone;
c) Lactulose;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident T's MAR chart dated 9 July 2021, and Resident V's PRN chart dated 9 July 2021 and noted that the

signatures do not appear to belong to Mrs Scanlon. The panel noted that the charge specifically says that Mrs Scanlon failed to document the running total of Adcal D3 tablets, Fludrocortisone, and Lactulose, however the panel previously found that it was not Mrs Scanlon's responsibility as Clinical Lead to document, but was instead the responsibility of the person giving the medication.

The panel therefore found these charges not proved.

Charge 21

21) On or around 9 July 2021, in relation to Resident U, failed to document the running total of Docusate following administration;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident U's MAR chart dated 9 July 2021 and noted that the signatures do not appear to belong to Mrs Scanlon. The panel noted that the charge specifically says that Mrs Scanlon failed to document the running total of Docusate following administration, however the panel previously found that it was not Mrs Scanlon's responsibility as Clinical Lead to document, but was instead the responsibility of the person giving the medication.

The panel therefore found these charges not proved.

Charges 22a and 22b

22) On or around 9 July 2021, in relation to Resident V, failed to:

a) document the running total of Docusate tablets following administration;
b) document the number of Docusate tablets administered;

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident V's PRN chart dated 9 July 2021 and noted that the signatures do not appear to belong to Mrs Scanlon. The panel noted that the charge specifically says that Mrs Scanlon failed to document the running total of Docusate following administration, however the panel previously found that it was not Mrs Scanlon's responsibility as Clinical Lead to document, but was instead the responsibility of the person giving the medication.

The panel therefore found these charges not proved.

Charge 23a

23) On an unknown date in February 2021, failed to investigate and/or escalate concerns that Colleague A:

a) had touched one or more female Resident inappropriately in a previous employment, resulting in dismissal;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's evidence of this concern, and also Mrs Scanlon's own statement dated 5 September 2021 in which she stated that her knowledge of Colleague A's previous conduct came from her then line manager. The panel considered that Mrs Scanlon believed that these concerns from the previous home had been dealt with. It further considered that Mrs Scanlon had no reason as to why she would not believe her manager and go above them to escalate her concerns

The panel also had sight of the original complaint email regarding Colleague A dated 7 February 2021. The panel noted that there is no indication from this email that Mrs Scanlon had any awareness of the concerns regarding Colleague A.

The panel therefore found this charge not proved.

Charge 23b

23) On an unknown date in February 2021, failed to investigate and/or escalate concerns that Colleague A:

b) was in an inappropriate relationship with a Resident at the Home;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's undated investigation report into Colleague A and noted that when asked if they had any concerns with any carers at Chapel Lodge Care Home, the Resident stated 'no concerns'.

The panel considered that there is no indication to suggest that Colleague A was in an inappropriate relationship with a Resident at the Home.

The panel therefore found this charge not proved.

Charges 24a and 24b

24) Between April 2021 and July 2021, on one or more occasions, failed to ensure audits were completed accurately in that you wrongly documented that there had been:

a) over 90% compliance in one or more medication audit;
b) over 90% compliance in one or more care plan audit;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

'[…] *I reviewed 100% of the documentation that could have been audited for the April, May and June 2021 medication audits and there was not over 90% compliance for any of the months.* […]*'*

The panel also took into account Mrs Scanlon's own statement dated 5 September 2021 which stated:

'[…] *The last audits that were completed by myself may indeed not have been accurate as I was working to a deadline which I felt pressured to meet* […] *I therefore felt that if I did not get them done as a matter of urgency that they would not be done at all I therefore completed them as best as I could under great pressure and with many distractions, interruptions and other outside pressures and demands, so I am afraid that these were done in a great rush and may not have been done as thoroughly as they should have been I absolutely admit to this and in hindsight wish that I had said that I had not had time to do them accurately* […]*.'*

The panel noted Mrs Scanlon's acceptance that the audits she completed were inaccurate and therefore found this charge proved.

Charge 25

25) On 6 July 2021, signed off an audit completed by a Colleague as correct when it was not;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

'[…] *I found errors on all of the audits I discuss below but I did not keep a record of the errors that I found so I am unable to provide specific examples.* […] *I discussed this audit with Ms Scanlon and explained that it was inaccurate. I did not take a note of this conversation but I told Ms Scanlon that*

the audit was not correct and she was not able to provide a response to this. […]*'*

The panel also had sight of the care documentation audit dated 6 July 2021 and noted that Witness 1 had signed this audit on 21 July 2021, with the comment 'discussed audit and action plan'. On this contemporaneous document, there is no mention by Witness 1 that the document is inaccurate, or otherwise incorrect.

The panel further noted the additional comments on the audit, which were completed by another nurse:

'Nurses are working with just one nurse and the deputy manager on duty on 6 hour shifts, the deputy manager has also been acting up as manager for the past week and a half.

Nurses are struggling to keep up with monthly evaluations as shifts are so busy, some weekend shifts only have one nurse on duty – all late shifts only have one nurse on duty after 4pm.

All night shifts only have nurse on duty.'

The panel, however, determined that this was not sufficient evidence to find this charge proved. The panel therefore found this charge not proved

Charge 26

26) On 7 July 2021, signed off an infection control audit as accurate when it was not;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

'[…] *This audit is incorrect as it says 'N/A' for sections 2.4, 4.8, 13.3, 13.7 but none of the sections can be 'not applicable', it would be that the standard has not been met.* […]*'*

The panel also took into account the Infection control audit dated 7 July 2021 which Mrs Scanlon had signed off on and noted that Witness 1 reviewed and signed the audit on 21 July 2021 with the note 'discussed as inaccurate'.

The panel further took into account Mrs Scanlon's own reflection dated 5 September 2021 which stated:

'[…] *The last audits that were completed by myself may indeed not have been accurate as I was working to a deadline which I felt pressured to meet* […]'

The panel therefore found this charge proved on the balance of probabilities.

Charge 27

27) Failed to identify and/or ensure, on one or more occasions, that Continuing Healthcare Checklist Assessments were completed for those Residents that qualified for additional funding;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

'[…] [Witness 2] *had spoken to Ms Scanlon in April 2021 and asked that CHC checklists were completed but in July 2021 they still had not been completed.* […] *I spoke to Ms Scanlon about the CHC checklists again on 9 August 2021 and again she told me that she would not be completing them as she only carried out needs assessments. I told her that she needed to complete the checklists. By September 2021 the checklists had still not been completed.* […]*'*

The panel considered that it was not taken into account that Mrs Scanlon was suspended two days after Witness 1 spoke with her on 9 August 2021 and told her that she needed to complete the checklists.

The panel also took into account Witness 2's witness statement which stated:

> *'*[…] *I am not aware of any policy that sets the threshold or trigger for when a CHC is required, but I would have expected Ms Scanlon* […] *to have identified when they were required through exercising their own professional judgement.* […]*'*

The panel further took into account Mrs Scanlon's own statement dated 5 September 2021 which stated:

> *'*[…] *I attempted to point out that we do not usually complete these documents as they are usually done by the assessing individual during an MDT* [Multi-Disciplinary Team] *meeting,* […] *I did try to point out that I was unfamiliar with this documentation because I had always been asked to complete a different one.* […]*'*

The panel considered that Mrs Scanlon had been in this position for an extended period of time and that she had been consistent within her statements that she was doing what she had always done. The panel acknowledged from other witness accounts that there were monthly audits and oversight of the Home. In her oral evidence, Witness 3 said that area managers would *"frequently be in the home".* The panel considered that there remains a question as to why this concern was not raised before April 2021 if Mrs Scanlon was not completing these Continuing Healthcare Checklist (CHC) Assessments consistently over time.

The panel therefore found this charge not proved.

Charge 28

28) Between April 2021 and August 2021 on one or more occasions failed, without justification, to follow management request to complete CHC assessments;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> *'*[…] [Witness 2] *had spoken to Ms Scanlon in April 2021 and asked that CHC checklists were completed but in July 2021 they still had not been completed.* […] *I spoke to Ms Scanlon about the CHC checklists again on 9 August 2021 and again she told me that she would not be completing them as she only carried out needs assessments. I told her that she needed to complete the checklists. By September 2021 the checklists had still not been completed.* […]*'*

This is corroborated by Witness 2's witness statement which stated:

> *'*[…] *The issue of outstanding CHC assessments for residents at the Home was raised with Ms Scanlon on a number of occasions-over a six month period,* […] *Despite Ms Scanlon being asked to complete them on a number of occasions, the CHC assessments remained outstanding.* […]*'*

The panel also took into account Witness 1's undated statement regarding CHC checklists which stated that a new manager started at the Home on 9 August 2021. The statement stated:

> *'*[…] *I met with both* [New Manager] *and Samantha and again discussed the completion of the CHC checklists, again Samantha stated that she was not completing them as she only completed needs assessments.* […]*'*

The panel further took into account Witness 3's witness statement which stated:

'[…] *During the disciplinary hearing we discussed the allegation that Ms Scanlon failed to carry out reasonable instructions from management in that she did not complete continuing healthcare checklists ('CHC checklists') when asked to do so.* […] *I understand that Ms Scanlon was asked to complete the CHC checklists on around three occasions spanning a period of several months from around April 2021 to August 2021. I do not know the names of the residents that this allegation related to, but I recall that there were multiple residents for which Ms Scanlon had not completed CHC checklists for. During the disciplinary hearing, I recall Ms Scanlon admitting that she had not completed the CHC checklists.'*

The panel further took into account Mrs Scanlon's own statement dated 5 September 2021 which stated:

'[…] *I am surmising however, that this refers to a conversation with* [Witness 1] *regarding some CHC checklists, 3 of which had been left on the nurses desk to be completed. I attempted to point out that we do not usually complete these documents as they are usually done by the assessing individual during an MDT meeting* […]*'*

The panel considered that even if Mrs Scanlon did not think that it was her responsibility to complete the CHC checklists, she failed to complete them when she was asked to do so and could not give a proper explanation for not doing it.

The panel therefore found this charge proved on the balance of probabilities.

Charge 29

29) On or around July 2021, failed to ensure that medication kept in the fridge was appropriately labelled to indicate when it had been opened;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

> *'*[…] *None of the boxed* [sic] *or bottled medication was dated to indicate when it was opened.* […]*'*

The panel also took into account the photograph within the evidence bundle of various medications seemingly on the shelves of a fridge and considered that the photograph does not, in isolation, show the panel everything that it would need to see to determine whether or not the medication was appropriately labelled.

The panel further considered that it does not have sight of the Home's medication policy setting out the requirements for storing medication in the fridge.

The panel determined that the NMC have not satisfied their evidential burden in relation to this charge and therefore found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Scanlon's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

the circumstances, Mrs Scanlon's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *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 where Mrs Scanlon's actions amounted to misconduct. He submitted that the areas of concern identified in this case relate to basic nursing skills and practises. He further submitted that Mrs Scanlon failed to provide safe and effective care to residents in her care and that a fellow practitioner would find her actions deplorable.

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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Malik submitted that limbs a, b, and c of *Grant* are engaged in this case. He submitted that although Mrs Scanlon did not cause actual harm to a patient, she did put residents at unwarranted risk of harm. He submitted that Mrs Scanlon's actions

have breached fundamental tenets of the nursing profession, and brought the nursing profession into disrepute.

Mr Malik submitted that Mrs Scanlon has not provided a reflective statement, or any evidence to demonstrate that she has developed insight or undertaken any training to remediate or strengthen her practice, so as to mitigate future risk. Mr Malik therefore submitted that in the absence of full insight and remediation, there is a risk of the conduct being repeated.

Mr Malik invited the panel to find current impairment on the grounds of public protection and public interest to mark the unacceptability of the behaviour, emphasise the importance of the fundamental tenets breached, and to reaffirm proper standards of behaviour.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin), and *Grant.*

Decision and reasons on misconduct

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

The panel was of the view that Mrs Scanlon's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Scanlon's 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*
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 *complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

10.3 *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.2 *keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs*

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*

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 *keep to and uphold the standards and values set out in the Code.'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the charges found proved in turn.

Regarding charges 1c, 1d, and 1f, the panel considered that Mrs Scanlon's documentation errors and failure to take appropriate action in a timely manner is serious and was repeated over an extended period of time. The panel determined

that Mrs Scanlon's actions fell short of the professional standards expected of a registered nurse and therefore amount to misconduct.

Regarding charge 5, the panel considered that this charge relates to medication not being charted appropriately. The panel determined that this conduct amounted to a failure of basic nursing practice and would be considered deplorable by another registered nurse. The panel therefore determined that Mrs Scanlon's actions amounted to misconduct.

Regarding charges 6a, and 6b, the panel only considered misconduct in relation to charge 6a due to the duplication and similarities of the charges. The panel determined that Mrs Scanlon's actions fell short of the professional standards expected of a registered nurse and put residents at unwarranted risk of significant harm by failing to ensure adherence to the relevant care plan. The panel further determined that this conduct breached one of the fundamental tenets of the nursing profession and therefore amounts to misconduct.

Regarding charges 11a, 11b, and 11c, the panel considered that it would expect a registered nurse to be aware of appropriate medications management and that it is not safe practice to save open medication ampules for later usage, but they should instead be discarded appropriately. The panel determined that Mrs Scanlon's actions in relation to these charges were failures of basic nursing practice which would be considered deplorable by other registered nurses. The panel therefore determined that these charges amount to misconduct.

Regarding charges 12a, and 12c, the panel determined that Mrs Scanlon's actions fell short of the professional standards expected of a registered nurse and put residents at unwarranted risk of significant harm by failing to ensure the expected detail was documented. The panel further determined that this conduct breached one of the fundamental tenets of the nursing profession and therefore amounts to misconduct.

Regarding charge 15, the panel determined that Mrs Scanlon's actions fell short of the professional standards expected of a registered nurse and put residents at

unwarranted risk of significant harm by failing to ensure the expected detail was documented. The panel further determined that this conduct breached one of the fundamental tenets of the nursing profession and therefore amounts to misconduct.

Regarding charges 24a, and 24b, the panel considered that these charges relate to Mrs Scanlon's direct responsibility to verify the audits and comply with medication and care plans. The panel considered that in failing to achieve the necessary accuracy, this could have led to serious nursing error and put residents at unwarranted risk of harm. As such, the panel determined that Mrs Scanlon's actions fell short of the standards expected of a registered nurse and therefore amounts to misconduct.

Regarding charge 26, the panel considered that this charge relates to Mrs Scanlon's direct responsibility to verify the audits. The panel considered that in failing to achieve the necessary accuracy, this could have led to serious nursing error and put residents at unwarranted risk of harm. As such, the panel determined that Mrs Scanlon's actions fell short of the standards expected of a registered nurse and therefore amounts to misconduct.

Regarding charge 28, the panel considered that it was Mrs Scanlon's responsibility as an employee appointed as Clinical Lead and Deputy Home Manager to complete the CHC checklists when requested to do so by the Company. The panel considered that failing to follow these instructions and comply with the request of the Company was unreasonable of Mrs Scanlon. However, in this situation, the panel considered this to be an issue between Mrs Scanlon, as an employee, and the Company, and not directly linked to Mrs Scanlon's nursing practice. The panel therefore determined that this charge does not amount to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 February 2024, which states:

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must 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 considered that residents were put at risk of unwarranted harm as a result of Mrs Scanlon's misconduct. Further, Mrs Scanlon's misconduct had breached some of the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered the factors set out in the case of *Cohen* and determined that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Scanlon has taken steps to strengthen her practice. The panel noted that Mrs Scanlon has not worked as a registered nurse since her dismissal on 6 September 2021. It further noted that she has not provided any evidence of remediation or steps taken to strengthen her practice. The panel took into account Mrs Scanlon's own statement dated 5 September 2021 and considered that Mrs Scanlon has not acknowledged the impact of her misconduct on the residents in her care, her colleagues, or the wider nursing profession. The panel considered that Mrs Scanlon has demonstrated limited insight and remorse and determined that this is not sufficient to determine that the risk of repetition and subsequent risk of serious harm has been eliminated in this case.

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

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that Mrs Scanlon's misconduct brought the nursing profession into disrepute and that a member of the public would be deeply concerned if a finding of current impairment was not made. The panel concluded that public confidence in the nursing profession and the NMC as the regulator would be undermined if a finding of impairment were not made in this case and therefore finds Mrs Scanlon's fitness to practise also impaired on the grounds of public interest.

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

Sanction

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

In reaching this decision, the panel 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.

Submissions on sanction

Mr Malik informed the panel that in the Notice of Hearing, dated 7 May 2025, the NMC had advised Mrs Scanlon that it would seek the imposition of a conditions of practice order for a period of two years if it found Mrs Scanlon's fitness to practise currently impaired.

Mr Malik submitted that taking no further action or imposing a caution order would not be appropriate in this case given the serious nature of the charges found proved and the lack of remediation from Mrs Scanlon.

Mr Malik submitted that there are workable and practical conditions that could be implemented to sufficiently protect the public and meet the public interest. He therefore submitted a conditions of practice order is an appropriate and proportionate sanction in this case.

Mr Malik submitted that Mrs Scanlon has indicated that she does not intend to practise as a registered nurse in the future. He further submitted that if Mrs Scanlon does not agree to comply with conditions, and given the lack of evidence of developed insight, a suspension order may be more appropriate. However, Mr Malik submitted that it is too early to reach that conclusion without a further period of managed and supervised practice if Mrs Scanlon did choose to return to nursing.

Mr Malik submitted that a striking-off order would be disproportionate at this stage.

Mr Malik therefore invited the panel to impose a conditions of practice order for a period of two years.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Lack of insight into failings
- Lack of remediation or strengthened practice
- A pattern of misconduct over a period of time
- Conduct which put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- Challenging work environment at the Home

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Scanlon's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Scanlon's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *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 workable, measurable, appropriate, and proportionate conditions which would address the failings highlighted in this case as well as sufficiently protect the public and meet the public interest. The panel considered that the concerns relate to Mrs Scanlon's clinical practice, particularly her assurance of documentation, record keeping, and medications management.

The panel took into account that Mrs Scanlon has not worked as a registered nurse since her dismissal on 6 September 2021. It acknowledged that Mrs Scanlon has not indicated that she is willing to comply with conditions. It further noted Mrs Scanlon's previous contemplation to apply for voluntary removal from the NMC register, as well as her declaration in an email to the NMC dated 6 March 2025 in which she said that she had *'already decided that I will never practice again and have not paid registration fees for 3 years'.* However, the panel considered that prior to these concerns being raised, Mrs Scanlon had a long-standing period of safe and effective practice and should therefore be given the opportunity to demonstrate strengthening of her practice.

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

For the reasons set out above, 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 Mrs Scanlon's case.

Having regard to the matters it has identified, the panel has 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 limit your nursing practice to one substantive employer. This may be an agency or bank work.
>
> 2. You must not be employed in a supervisory or managerial role which entails sole responsibility for the assurance of other professionals’ record keeping or drug administration until you have been assessed as competent by another registered nurse of the same or higher band.
>
> 3. You must undertake and successfully complete a course in safe medication administration. You must provide your NMC case officer with evidence of completion of this course within seven days of completion.
>
> 4. You must undertake and successfully complete training relevant to the following:
>
>   - accurate record keeping
>   - information/data management
>   - documentation of audits.

You must provide your NMC case officer with evidence of completion of this training within seven days of completion.

5. You must work with a line manager, supervisor, and/or mentor who is at a minimum one band above your own band, to create a Personal Development Plan (PDP). You must meet monthly with this line manager, supervisor, and/or mentor to discuss your progress and reflect on your practice. Your PDP must address the concerns in relation to, but not limited to management responsibilities and the importance of accurate records, medication administration, and record keeping.

   You must send your NMC case officer a copy of your PDP before any NMC review hearing. This report must show your progress towards achieving the aims set out in your PDP.

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

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

8. 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.

9. 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.

10. 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 two years.

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

Any future panel reviewing this case would be assisted by:

- A reflective piece relating to the charges that have been found proved in this case.

- References and testimonials from your current employer that details your performance in relation to the assurance of medication administration, documentation and record keeping.

This will be confirmed to Mrs Scanlon in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Malik. He submitted that an interim conditions of practice order for a period of 18 months would be appropriate to allow time for any possible appeal.

The panel accepted the advice of the legal assessor.

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 time for any possible appeal.

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

That concludes this determination.