Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 28 October 2024 – Friday, 1 November 2024
Thursday, 27 March 2025 – Monday, 31 March 2025

Virtual Hearing

Name of Registrant:	Anita Colton	
NMC PIN:	90Y0027N	
Part(s) of the register:	Nurses Part of the Register – Sub Part 1 RN3: Mental Health Nurse, level 1 (17 March 1994)	
Relevant Location:	Cambridgeshire	
Type of case:	Misconduct	
Panel members:	Nicholas Rosenfeld Jane Lewry Janine Green	(Chair, lay member) (Registrant member) (Lay member)
Legal Assessor:	Abigail Stamp	
Hearings Coordinator:	Catherine Blake (28 October 2024 – 1 November 2024) Samantha Aguilar (27 March 2025 – 31 March 2025)	
Nursing and Midwifery Council:	Represented by Tom Hoskins, Case Presenter	
Ms Colton:	Present and represented by Karl Shadenbury, instructed by UNISON	
Facts proved:	Charges 1, 2a, 2b, 4 and 6	
Facts not proved:	Charges 3, 5 and 7	

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Hoskins, on behalf of the Nursing and Midwifery Council ("NMC"), to amend the wording of charges 1, 2a, 2b, 3 and 7.

Mr Hoskins submitted that the proposed amendments in charges 1 and 3, namely the addition of *'one or more'*, would allow the panel more flexibility to consider the case in fulfilling its public functions. He submitted that the original wording would require a significantly higher evidentiary threshold to be found proved, when the mischief of the charge is medication misadministration, and this can be established in one instance.

Mr Hoskins submitted that the proposed amendments in charges 2a and 2b were appropriate for the same reasons as above.

Mr Hoskins submitted that the proposed amendment in charge 7 was to correct a spelling error.

It was submitted by Mr Hoskins that the proposed amendments would provide clarity and enable the panel to more effectively discharge its public duty. He submitted there would be no injustice to the registrant in allowing these amendments.

'That you, a registered nurse,

1) *On 28 January 2021 failed to **correctly** sign medication charts for **one or more of the** 12 patients shown in schedule 1 below*

2) *On 28 January 2021,*

    a) *Did not administer Bactroban nasal spray and**/or** Paracetamol to Patient F*

b) *Signed Patient F's MAR chart to say that you had administered Bactroban nasal spray and**/or** Paracetamol to Patient F at 22:00hrs,*

3) *On 29 January 2021 failed to **correctly** sign medication charts for **one or more of the** 15 patients shown in schedule 1 below.*

4) *On 30 January 2021 prepared the incorrect dosage of Risperidone for Patient B*

5) *On 30 January 2021 failed to administer medication to Patient C, Patient D, Patient E, Patient H, Patient M and Patient G*

6) *On 5 April 2021 dispensed medication whilst sat on the floor*

7) *Your action in charge 2) a) and/or 2) b above were dishonest as you intended to ~~enduce~~ **induce** others to believe the Bactroban nasal spray and paracetamol had been correctly administered when it hadn't been as it was on order and the paracetamol for Patient F had not been prescribed until 29 January 2021.*

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

The panel heard from submissions from Mr Shadenbury, on your behalf. He informed the panel he objected to the inclusion of the word *'correctly'* in charges 1 and 3. Mr Shadenbury submitted that the original wording of the charge was a failure to sign the Medication Administration Record ("MAR") charts on the basis that it was not clear if the medication had been administered by you.

Mr Shadenbury submitted that the proposed amendment would then seek to demonstrate that you signed the MAR charts but that this was not done correctly. He submitted that the

standard of correctness is unknown as the NMC has not exhibited the Trust policy in respect of signing MAR charts, and therefore the panel could not safely determine whether the way in which you signed the MAR charts was correct or not.

Mr Shadenbury did not object to the other amendments.

In response, Mr Hoskins submitted that the record keeping of MAR charts is a daily function carried out by nurses, and that the panel can be assured of the expertise of the Registrant Member in determining whether the MAR charts were signed correctly in the absence of the Trust Policy.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended ("the Rules").

The panel was of the view that the amendments of charges 1, 2a, 2b and 3, as applied for, were in the interest of justice. The panel determined that such amendments better represent the concerns and best enable the panel to discharge their duty to the public. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed.

The panel also determined to allow the proposed amendment of charge 7 ensure clarity and accuracy.

During deliberation of charge 6, the panel noted there was factual dispute as to whether you sat or crouched on the floor. It noted the submissions of the NMC that the panel can amend charges of its own volition under Rule 28. The panel considered that the mischief in this charge goes to unsafe medicines practice, namely the risk of infection, and proposed to amend the charge to better reflect the evidence it has heard:

> *'That you, a registered nurse, on 5 April 2021 dispensed medication ~~whilst sat on the floor~~* ***into pots which were on the floor****'*

The panel heard submissions from the parties in respect of the proposed amendment. Mr Hoskins noted that the charge goes to a risk of infection and therefore submitted that the proposed amendment may be made without injustice.

Mr Shadenbury indicated that he did not oppose the amendment.

The panel heard and accepted the advice of the legal assessor. It determined allow the proposed amendment to better reflect the evidence.

Details of charge

That you, a registered nurse,

1) On 28 January 2021 failed to correctly sign medication charts for one or more of the 12 patients shown in schedule 1 below

2) On 28 January 2021,

    a) Did not administer Bactroban nasal spray and/or Paracetamol to Patient F

    b) Signed Patient F's MAR chart to say that you had administered Bactroban nasal spray and/or Paracetamol to Patient F at 22:00hrs,

3) On 29 January 2021 failed to correctly sign medication charts for one or more of the 15 patients shown in schedule 1 below.

4) On 30 January 2021 prepared the incorrect dosage of Risperidone for Patient B

5) On 30 January 2021 failed to administer medication to Patient C, Patient D, Patient E, Patient H, Patient M and Patient G

6) On 5 April 2021 dispensed medication into pots which were on the floor

7) Your action in charge 2) a) and/or 2) b above were dishonest as you intended to induce others to believe the Bactroban nasal spray and paracetamol had been correctly administered when it hadn't been as it was on order and the paracetamol for Patient F had not been prescribed until 29 January 2021.

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

Schedule 1

Patient A
Patient B
Patient C
Patient D
Patient E
Patient F
Patient G
Patient H
Patient I
Patient J
Patient K
Patient L
Patient M
Patient N
Patient O

Background

The charges arose whilst you were employed as an Agency Nurse by [PRIVATE] ("the Agency") and working at the [PRIVATE] ("the Trust"). The Trust reported that there were concerns with your clinical practice and ability to perform the medication rounds unsupervised as you had allegedly failed to sign 12 patient medication charts on 28 January 2021, prepared the incorrect dosage of Risperidone, and failed to administer medication to patients.

It is further alleged that, while working for the [PRIVATE] ("the Hospital") you dispensed medication whilst sitting on the floor.

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 Hoskins on behalf of the NMC and by Mr Shadenbury, on your behalf.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Senior clinical nurse at the Hospital at the time of the charges.
- Witness 2: Registered nurse at the Trust at the time of the charges.
- Witness 3: Registered nurse at the Trust at the time of the charges.

- Witness 4: Registered nurse at the Trust at the time of the charges.

The panel also heard evidence from you under affirmation.

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

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

Charge 1

1) That you, a registered nurse on 28 January 2021 failed to correctly sign medication charts for one or more of the 12 patients shown in schedule 1 below

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 2, Witness 3, Witness 4. The panel also took into account the MAR charts for the patients in Schedule 1.

The panel bore in mind that in order for this charge to be found proved there needed to be an obligation on you to correctly sign the MAR charts.

The panel has seen evidence that you were the only nurse on shift at the time of the medication round on 28 January 2021. The panel heard evidence that there was no one else on the ward who could administer the medication. The panel also heard evidence from Witness 2 and Witness 3 regarding the medication administration process at the

Trust, and that the MAR chart should be signed by the person administering the medication.

The panel has also seen the MAR charts for the patients and noted that other nurses had signed the charts following administration of medication. Despite not having sight of the Trust's medication administration policy, the panel determined that you did have an obligation to correctly sign the patients' MAR charts.

The panel regarded the NMC submissions that you failed to correctly sign each of the 12 MAR charts due to either not signing the charts or signing them retrospectively.

Not signed

The panel considered the following:

- Patient A's MAR chart, and three of their prescribed medications (1, 7 and 8)
- Patient B's second MAR chart, and two of their prescribed medications (5 and 6)
- Patient E's first MAR chart, and one of their prescribed medications (4)
- Patient K's MAR chart, and three of their prescribed medications (2, 3, and 6)

The panel noted that the boxes for these medications are blank on the relevant date when you were working as the only registered nurse on shift. The panel took into account your written statement:

'If I failed to sign 12 charts I can only think it was my intention to sign them'

The panel also noted that in your oral evidence you could not explain why the MAR charts had not been signed.

Taking into account all this information, the panel determined that you did not sign the MAR chart for the patients listed above. Accordingly, on the balance of probabilities in relation to these patients, this charge is found proved.

Signed retrospectively

The panel next took into account the submissions of the NMC that some of the medications were signed retrospectively by you.

The panel took into account Patient B's first MAR chart, and four of their prescribed medications (3, 5, 6, and 8).

The panel noted that the boxes for these medications were signed as administered by you at 22:00 on 28 January 2021. The panel considered the NMC submissions that you signed these entries retrospectively.

The panel had regard to the supplementary statement of Witness 3 dated 29 October 2024, which included an incident report form dated 2 February 2021 concerning the events of the evening of 28 January 2021:

> *'I completed the incident report into the events, which I understood to be that the Registrant "Only signed 1 out of 13 medication charts, other charts left blank.* [She] [d]*id sign next day with lots of prompts. concerns raised over medication competencies", as I noted. I do not recall if I myself assisted the Registrant in signing the drug charts the following day, namely 29 January 2021, or someone else did, but I do recall it was [Witness 2] who had raised concerns with clinical leads that the charts were not signed which led to the incident report being made.'*

The NMC asked the panel to infer that the MAR charts for Patient B were retrospectively signed on the basis of this incident form.

The panel noted that while the incident form was a near contemporaneous account, Witness 4 is reporting information reported to her by others. The report does not specify

who informed Witness 4 of the errors and does not specify what these errors were. Whilst the panel did not consider that this report relied on inaccurate recounts, due to the lack of specificity and that the panel has not had an opportunity to test this evidence, the panel were not satisfied that it was sufficient to prove on the balance of probabilities that the MAR chart was signed retrospectively. The panel similarly considered that, while Witness 2's oral evidence supported the NMC submission that MAR charts were left blank, Witness 2 could not provide specificity.

Accordingly, the panel did not consider that this MAR chart was signed incorrectly and on the balance of probabilities in relation to Patient B, found this charge not proved.

The panel next took into account the following;

- Patient C's MAR chart, and five of their prescribed medications (1, 3, 6, 7, and 9)
- Patient E's first MAR chart, and one of their prescribed medications (6)
- Patient F's first MAR chart, and one of their prescribed medications (6)
- Patient G's MAR chart, and three of their prescribed medications (1, 4 and 9)
- Patient H's MAR chart, and two of their prescribed medications (1 and 3)
- Patient I's first MAR chart, and three of their prescribed medications (3, 5, and 6)
- Patient I's second MAR chart, and one of their prescribed medications (4)
- Patient L's MAR chart, and one of their prescribed medications (9)
- Patient M's MAR chart, and two of their prescribed medications (3 and 7)
- Patient N's first MAR chart, and two of their prescribed medications (4 and 9)
- Patient N's second MAR chart, and one of their prescribed medications (2)
- Patient O's first MAR chart, and two of their prescribed medications (1 and 7)
- Patient O's second MAR chart, and one of their prescribed medications (5)
- Patient O's third MAR chart, and four of their prescribed medications (3, 4, 5 and 6)

The panel noted that the boxes for all these medications were signed as administered by you on 28 January 2021. The panel considered the NMC submissions that you signed these entries retrospectively but were not satisfied that the evidence in support was

sufficient to prove on the balance of probabilities, as outlined above. Accordingly, the panel did not determine that this MAR chart was signed incorrectly and in relation to the medication entries listed above, found this charge not proved.

However, in respect of Patient E's first MAR chart, and one of their prescribed medications (9), the panel noted that while this medication was signed as administered by you on 28 January 2021, it was not prescribed until 29 January 2021 and would not have appeared on Patient E's MAR chart until then. Taking into account all the information the panel determined that it is more likely than not that this was a retrospective entry by you and therefore this charge is found proved in respect of medication 9 for Patient E.

The panel next considered Patient F's second MAR chart and one of their prescribed medications (2) Paracetamol syrup. The panel again noted that while you signed it as administered on 28 January 2021, it was not prescribed until 29 January 2021.

The panel also note that the same medication is prescribed on the Medicines Given as Required Record ("MGRR") for Patient F. The suggestion is that you administered this medicine given as required on 28 January 2021 and accidentally recorded this on the MAR chart instead of the MGRR. The panel reject this explanation as, similar to medication 98 for Patient E above, the Paracetamol syrup would not have appeared on the MAR chart at the time it was signed as given.

The panel then considered the second MAR chart of Patient F, and one of their prescribed medications (1) Bactroban.

The panel saw evidence that this medication was prescribed on 28 January 2021. The panel drew reference to a *'4'* that is entered at 13:00 on 28 January 2021 and indicates that the medicine was on order. The panel also drew reference that a *'4'* is entered on 29 January 2021 at 08:00 and 13:00, indicating that the medicine is still on order.

The panel took into account an entry on Patient F's notes dates 28 January 2021 that the medication in question was *'to be ordered from pharmacy when open'*. The panel heard from Witness 4 that this medication is prescribed on order on an individual patient basis and would not have been available on the ward as a stock item. Therefore, the panel determined that it was more likely than not that your signature was added retrospectively to the MAR chart for 28 January 2021, and found this charge proved in respect of that entry.

The panel heard oral evidence from Witness 4 that the pharmacy would bracket potential errors within the MAR charts with a green pen. The panel noted other examples where a green bracket has been entered on the MAR chart in the event of errors, such as a missing signature. The panel accepted Witness 4's evidence that this was the pharmacy's process for highlighting errors. The panel note that the signed entry for the Bactroban has green brackets around your signature and accept the NMC submission that this was the pharmacy highlighting a potential error. Therefore, on the balance of probabilities, the panel determined that it was more likely than not that your signature in this entry was retrospective and accordingly this charge is found proved in respect of the Bactroban for Patient F.

The panel next took into account the following:

- Patient G's first MAR chart, and three of their prescribed medications (1, 2 and 9)
- Patient G's second MAR chart, and one of their prescribed medications (1)
- Patient J's MAR chart, and two of their prescribed medications (1 and 2)
- Patient M's MAR chart, and one of their prescribed medications (5)

The panel noted that your signatures in respect of these medications are bracketed in green pen. As above, the panel determined that this indicates that it is more likely than not that this is a retrospective signature, and therefore find this charge proved in respect of Patient G.

The panel noted that the charge has been drafted broadly, and the NMC submissions that due to this there was no need to be patient specific. The panel has taken a holistic view of its findings and is satisfied on the balance of probabilities that the charges found proved reflect the gravity of the charge. Accordingly, this charge is found proved.

Charge 2

2) On 28 January 2021,

a) Did not administer Bactroban nasal spray and/or Paracetamol to Patient F

b) Signed Patient F's MAR chart to say that you had administered Bactroban nasal spray and/or Paracetamol to Patient F at 22:00hrs

This charge is found proved.

In reaching this decision, the panel took into account the Patient F's second MAR chart.

The panel also took into account Mr Shadenbury's closing submissions, in which he invited the panel to find charge 2a proved on the balance of probabilities.

For the reasons the panel gave in charge 1 regarding Patient F's second MAR chart and the prescribed medication 2 of Paracetamol syrup, the panel determined that charges 2a and 2b are found proved.

Charge 3

3) on 29 January 2021 failed to correctly sign medication charts for one or more of the 15 patients shown in schedule 1 below.

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 2.

The panel bore in mind that in order for this charge to be found proved there needed to be an obligation on you to correctly sign the MAR charts.

The panel took into account the following from Witness 2's written statement:

> *'On 29 January 201*[sic]*, during my shift with the registrant, I did the medication round with her and she seemed frightened to do anything so I took the lead and administered the medications and showed her how to do everything. As such, there were no incidents.'*

The panel also took into account the following from Witness 2's oral evidence:

> *'I was leading and initiating, she was not responsible for signing meds on 29 January 2021.'*

In response to panel questions, Witness 2 stated that it was during the administration of medication to the first patient that you seemed frightened so he took the lead in administering the medication to the patient and completing the round to ensure that everyone was safe.

Witness 2 also said it was never appropriate for others to sign the MAR chart on behalf of someone else. The panel accepted the evidence that during the medication round, Witness 2 took the lead and you were shadowing him. Therefore, the panel concluded that Witness 2 was responsible for signing the MAR chart, and not you. Accordingly, as there was no obligation on you to sign the MAR chart on 29 January 2021, this charge is found not proved.

Charge 4

4) On 30 January 2021 prepared the incorrect dosage of Risperidone for Patient B

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 3 and you.

The panel took into account the following from Witness 3's statement:

> *'The Registrant prepared Risperidone. Risperidone is a mental health drug which he* [sic] *used to treat agitation, hallucinations, add* [sic] *stress. It could affect somebody's mood or make them very drowsy if they are given too much. The registrant drew up risperidone liquid in a syringe but said there was none in the syringe. I had to point out to her that the medication was in the syringe. She had also drawn up the wrong amount, so I had to show her how much medication was in the syringe and correct the dosage.'*

This was supported by Witness 3's oral evidence.

You, in oral evidence, suggested that though you may have drawn up the incorrect amount of Risperidone, you were aware, and had you been afforded the opportunity, would have corrected the dosage. The panel noted that this explanation was not reflected in your written statement and was the first time that explanation was raised.

The panel preferred the evidence of Witness 3. Accordingly, the panel find charge 4 proved on the balance of probabilities.

Charge 5

5) That you, a registered nurse, on 30 January 2021 failed to administer medication to Patient C, Patient D, Patient E, Patient H, Patient M and Patient G

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 3 and you.

The panel bore in mind that in order for this charge to be found proved there needed to be an obligation on you to administer medication to the listed patients on 30 January 2021.

The panel has seen evidence that Witness 3 was supervising you during the medication round on 30 January 2021 and took into account the following from Witness 3's written statement:

'…I supported her through the entire medication round
…
'On the 30th of January 2021, I supervised the registrant the entire time so there were no medication administration errors'

This was corroborated in oral evidence that:

'I ensured all medication was administered correctly'

The panel accepted the evidence of Witness 3 and was satisfied that the medication was administered correctly on 30 January 2021.

Witness 3 informed the panel that that while you did not fail to administer medication, you would have if Witness 3 were not there. However, the panel determined that you were being supervised during this medication round, and as such was not satisfied on the balance of probabilities that the obligation to administer the medication to Patient C,

Patient D, Patient E, Patient H, Patient M and Patient G on 30 January 2021 rested solely on you.

Accordingly, this charge is found not proved.

Charge 6

> 6) That you, a registered nurse, on 5 April 2021 dispensed medication into pots which were on the floor

This charge is found proved.

In reaching this decision, the panel took into the written and oral evidence of Witness 1 and you.

In particular, the panel noted the following from Witness 1's written statement:

> *'*[W]*hen I went into the clinic room, I saw the registrant was on the floor with the drug charts. I found this quite strange and told her that she shouldn't sit awful*[sic] *as it could be dirty, and we have a trolley for the charts. The registrant responded find*[sic] *she then got off the floor and left the room. when*[sic] *I'm back a short while later the registrant was back on the floor again but this time, she was also dispensation*[sic] *from the floor.'*

The panel accepted the evidence of Witness 1. The panel had the benefit of hearing from Witness 1 in live evidence and considered that her evidence was credible and consistent.

The panel took into consideration your oral evidence in which you stated that you were crouched on the floor and that while the MAR charts were on the floor, the medicine pots would have rested on your knees. However, in response to cross examination, you did accept that the pots could have been on the floor.

Having considered the evidence before it, and determining Witness 1 a credible and reliable witness, the panel determined that on the balance of probabilities it is more likely than not that you were dispensing medication into pots which were on the floor on 5 April 2021. Accordingly, this charge is found proved.

Charge 7

7) Your action in charge 2) a) and/or 2) b above were dishonest as you intended to induce others to believe the Bactroban nasal spray and paracetamol had been correctly administered when it hadn't been as it was on order and the paracetamol for Patient F had not been prescribed until 29 January 2021.

This charge is found NOT proved.

In reaching this decision, the panel took into account the MAR chart of Patient F, and the oral evidence of Witness 4, as well as your written and oral evidence.

In its deliberation, the panel took into account the context of the shift of 28 January 2021, and that it was your first shift on your own as the nurse in charge having not had an induction. In particular, the panel noted the following from your reflective statement, submitted in your defence bundle:

'On arrival at the unit, I was given a very hasty description of what sort of care was delivered there, what sort of service users etc. And a report for each individual, their condition or progress during the day. I didn't receive an induction or walk around the unit, I was shown the clinical room, given the medicine keys and told that "I'd be fine".

I was completely overwhelmed because I became aware that I was the only trained member of staff and had no one to refer to if I was unsure. I panicked to think I had a medication round to deliver to service users I didn't know, and I wanted a member

of the care staff to come with me and identify the service users and how they took their medication. I did receive some help, but the ward was understaffed completely regarding the enormity of the work involved. I carried out the medication round and hadn't given the wrong medication to anyone and then I went and helped the care staff to deliver the care.'

The panel considered these extracts give an indication as to your state of mind at the date of the charge.

The panel also drew reference to your oral evidence:

'Nothing was deliberate, the fear I felt and the pandemic and the whole situation was not good. I felt under a lot of pressure. I did not deliberately seek to mislead anybody.'

The panel also took into account your good character.

The panel drew further reference to the oral evidence of Witness 4, who stated in relation to medication 2 for Patient F that your retrospective signature was *"careless not dishonest"*.

The panel determined that the retrospective signatures in Patient F's MAR chart were more likely than not to be characterised as reckless rather than dishonest. The panel noted the NMC Guidance on determining dishonesty charges and was not satisfied there was evidence before it that you had dishonesty in your mind at the time of signing the MAR chart. Therefore, the panel was not satisfied on the balance of probabilities that your actions at charge 2 were dishonest. Accordingly, this charge is found 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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

Mr Hoskins provided the panel with written submissions and referred the panel to *Roylance, Meadow v General Medical Council, Remedy UK Ltd v General Medical Council*

[2010] EWHC 1245 (Admin) and *Shaw v General Osteopathic Council* [2015] EWHC 2721 (Admin).

Mr Hoskins submitted that in respect of charges 1 and 2, there were 19 instances of failures to correctly sign medication which affected eight patients. In respect of charge 4, the extent of the incorrect preparation of Risperidone "*was such that your actions failed to take account of objective realities (the presence of medication in the syringe at all) together with the fact that the amount of the medication was wrong."* Mr Hoskins submitted that this was an example of a patient being placed at risk of harm. In respect of charge 6, Mr Hoskins submitted that the mischief in this charge is the unsafe medication practice, which raises concerns relating to the risk of infection.

Mr Hoskins submitted that the charges found proved are clear breaches of the following parts of the NMC's Code of Conduct:

'a. Charges 1 and 2 constitute a breach of:

i. Paragraphs 8.2, 8.3, 8.5 of the Code in respect of since the MAR charts are ultimately a significant means of communication and a tool of cooperative care;

ii. Paragraph 10, in respect of the keeping of accurate records and specifically paragraph 10.3;

b. Charge 4 constitutes a breach of Paragraphs 18 and 19 of the code;

c. Charge 6 constitutes a breach of Paragraphs 6 and 19 of the code;

d. If the Panel accept the Registrant's explanation of the underlying issues at the time of the allegations, there are also breaches of Paragraphs 13 (specifically paragraphs 13.4 and 13.5) and 16 (specifically 16.2) in terms of working within the limits of her contextual abilities. '

Mr Hoskins stated in his written submissions that you were an experienced nurse with 29 years' work experience. Your expertise was in the care of the elderly and administration of medication and record keeping. The types of failings identified are a daily and central skill expected of nurses. He invited the panel to find that the charges found proved amounted to serious professional misconduct, particularly as this included attending to vulnerable older patients.

Mr Shadenbury also provided the panel with written submissions. He submitted that the mistake identified in Charge 1 should be considered as a record keeping error that occurred during a high-pressured situation. [PRIVATE] during a global pandemic. He submitted that the Trust themselves did not investigate this concern because the Trust did not deem the incident serious enough to warrant investigation. He also highlighted the evidence of Witness 4, who stated that mistakes in MAR charts were common. He submitted that this charge does not amount to misconduct.

In respect of charge 2(a), Mr Shadenbury submitted that this charge does not amount to misconduct as "*both medications had either not been available or not prescribed, and therefore it would have been correct that the Registrant did not administer either medication."* In respect of charge 2(b), he submitted that this charge does not amount to misconduct because you mistakenly signed the MAR chart and again this was a record keeping error in the context of a high-pressured situation. He invited the panel to consider the risk of harm in this charge to be minimal given that the Bactroban was not available and paracetamol was a prescribed pro re nata ("PRN"). He further added that the Trust had not investigated the concern at the time which had been identified within the incident form as *'no harm'.*

In respect of charge 4, Mr Shadenbury invited the panel to consider the context of this medication error in that, at the time of the incident, you had been wearing Personal Protective Equipment ("PPE") and therefore may have had some difficulties in clearly

being able to see the clear liquid being drawn into the syringe. Mr Shadenbury submitted that the incident was not investigated by the Trust which indicates that it was not so serious that it warranted an investigation.

In relation to charge 6, Mr Shadenbury invited the panel to consider the contextual factor in that you had been in a car accident that day and did not seem right. Witness 1 gave evidence that none of the medication dispensed on the floor was administered to patients, and therefore, he submitted that this charge does not amount to misconduct.

Submissions on impairment

Mr Hoskins moved on to the issue of impairment and addressed the panel through written representations 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 Hoskins submitted within his written representations in respect of charges 1, 2 and 4, that those who worked alongside you perceived that the concerns gave rise to a risk of harm in the future, had it not been for their intervention. Further, despite your lengthy career as a nurse, you took shifts after concerns were identified and your actions in relation to medication and administration and/or record keeping were repeated.

Mr Hoskins submitted that it is the NMC's position that the concerns are remediable. However, in considering the extent which they had been remedied, he submitted that you have not worked as a nurse since 2021, which diminishes the value of the reference that you provided which referred to a period of work which pre-dated the misconduct. He submitted that this poses a risk of repetition and demonstrates a lack of remediation.

Mr Hoskins referred to the two certificates provided by you. He submitted that these are of a relatively basic nature and does not provide detail to demonstrate the scope of work that you have taken and whether training was embedded.

In addressing your insight, Mr Hoskins submitted that whilst you demonstrated the capacity to apologise and understand your failings, your insight alone does not sufficiently mitigate the risks of repetition.

Mr Shadenbury provided the panel with written submissions. He submitted that in considering the test laid out in *Grant*, you have not acted in the past and nor are you liable to put patients at risk of unwarranted harm in the future. He submitted that no patients were placed at risk of unwarranted harm, and in respect of charge 4, you did not seek to administer the medication that had been incorrectly drawn up and therefore, no harm was caused to patients. In relation to charge 6, he submitted that these were not administered to patients because Witness 1 had disposed of these.

In addressing whether you brought the profession into disrepute, and whether you are likely to do so in the future, Mr Shadenbury submitted that you accepted that your actions were wrong but your actions have not negatively impacted on the reputation of the profession or brought it into disrepute.

Mr Shadenbury submitted that you have not, in the past, committed a breach of one of the fundamental tenets of the profession and nor are you liable to do so in the future. You sought to act professionally and effectively as a nurse, and the isolated incidents should be considered in the context of a global pandemic, and in respect of charge 6, following a car accident.

Mr Shadenbury submitted that the concerns are easily remediable, and that you have taken steps to remediate. He referred the panel to your defence bundle and submitted that you demonstrated a good level of insight into the concerns, the impact of your actions on colleagues, service users and the wider profession. He submitted that you recognised that

you are not suited to working as the sole nurse and therefore have not taken shifts where you are the only registered nurse. You also recognised that your conduct did not meet the required standards of a registered nurse.

Mr Shadenbury referred the panel to the training certificates and highlighted that you have been a nurse for 29 years and had practiced without incident. As such, the risk of repetition is highly unlikely and should be considered as an isolated incident borne out of a challenging period.

In addressing the public interest, Mr Shadenbury submitted that the charges found proved are not serious, and did not cause actual harm to patients, and any risk of harm to patients was minimal. Furthermore, your actions did not damage the reputation of the profession or the regulator. A well-informed member of the public would not expect a nurse facing such charges to have their practice found impaired. He invited the panel not to make a finding of current impairment on the grounds of public safety or public interest.

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*, *General Medical Council v Meadow [*2007] QB 462 (Admin), *Grant* and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

‘8 Work co-operatively

To achieve this, you must:

8.2 Maintain effective communication with colleagues.

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

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 Complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event.

10.2 Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.3 Keep to and promote recommended practice in relation to controlling and preventing infection.

19.4 Take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.

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.

Charge 1

The panel found your conduct in charge 1 constituted serious professional misconduct. The panel took into account that this took place during COVID-19 and therefore during a pressurised environment. It also took into account that there were errors made by other nurses on the MAR chart. Due to your lack of induction to the ward, you had taken steps to contact the nursing agency who had secured you the position to express your concerns. However, the panel noted that you were the only registered nurse on shift, the medication errors was serious, impacted on a wide range of patients and your actions which relate to failure to record when those medications were given, could have led to several risks and potential harm. Inaccurate medication records could have led to a risk of administering medication at the wrong time and other health care professionals could have unintentionally given patients another dose of the medication potentially leading to overdose. Failure to record medications administered on the MAR charts could have affected future clinical decision making, care planning, and future prescribing of medication which could have compromised patient safety. The panel bore in mind that these were vulnerable older patients in your care, as such, your failure to escalate your concerns and failure to correctly sign for medications did not promote patient safety.

Accordingly, the panel determined that your actions breached the fundamental tenets of the Code, namely, practising effectively, preserving safety and professionalism and trust. Your actions fell seriously short of the standards expected of a nurse and amounted to misconduct.

Charges 2a and 2b

The panel found your conduct in charges 2a and 2b to constitute serious professional misconduct to include retrospectively signing for medications either out of stock or not prescribed at the relevant time. The failure to record the medication given within the MAR charts had the potential to change the course of the patients' care and treatment.

Accordingly, the panel determined that your actions breached the fundamental tenets of the Code, namely, practising effectively, preserving safety and professionalism and trust.

Your actions fell seriously short of the standards expected of a nurse and amounted to misconduct.

Charge 4

The panel did not find that your conduct constituted serious professional misconduct. The panel took into account that in the preparation of the incorrect dose of Risperidone, you were supervised by another registered nurse and given that supervision, your actions did not constitute serious misconduct. The Risperidone was not administered to Patient B and the panel was satisfied that this was an isolated error. Further, the panel noted that you did not dispute that you drew up the incorrect amount of medication either during the supervision or before the panel.

Accordingly, the panel did not determine that your conduct in Charge 4 constituted serious professional misconduct.

Charge 6

The panel found that your conduct in charge 6 constituted serious professional misconduct. The panel took into account that this occurred in COVID – 19, a period in which infection prevention and control would have been paramount given the challenging environment and uncertainty posed by the pandemic. This incident occurred when there was no emergency and there was no reason for you to dispense medication from the floor. The panel determined that your actions increased the potential for patient harm in relation to infection prevention and control, particularly having regard to those patients, who you were dispensing medication to, were vulnerable.

Accordingly, the panel determined that your actions breached the fundamental tenets of the Code, namely, practising effectively, preserving safety and professionalism and trust. Your actions fell seriously short of the standards expected of a nurse and amounted to misconduct.

The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse in respect of charges 1, 2a, 2b and 6, and therefore amounted to misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones, especially during COVID-19, a period in which the public's trust in nurses would have been in the forefront of their minds particularly when visiting restrictions were in place.

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 found limbs a), b) and c) engaged in respect of your past conduct. The panel found that, you placed patients at unwarranted risk of harm in relation to infection prevention and control, not correctly signing MAR charts, and signing MAR charts that you had administered medication when you had not. Your actions breached the fundamental

tenets of the nursing profession and brought the reputation of the profession into disrepute.

The panel was satisfied that in respect of the future, limbs a), b) and c) remain engaged. The panel took the view that misconduct of this sort is capable of remediation. The panel next considered whether your misconduct in this case has been remediated. It took into account the circumstances surrounding the misconduct as well as your previous unblemished record. However, the panel concluded that the misconduct has not been remediated.

In reaching this decision, the panel determined that you showed some insight into the misconduct found proved. However, your reflection is not fully developed to include the impact upon patients, and the wider nursing profession.

The panel took into account your undated reflective statement and the following training certificates:

- Medication Training for Care issued on 6 November 2022.
- Certificate on administering medication awarded on 20 October 2024.
- A completion of a one-hour online training course for documentation and record keeping dated 22 March 2025.

In considering the most recent training certificate entitled *'Documentation and Record keeping'* dated 22 March 2025, the panel noted that there were ten learning outcomes of which the panel determined only one to be relevant to the misconduct found proved. The panel bore in mind that you have not practised as a nurse for nearly four years and have not been able to demonstrate how you have implemented any recent learning into your nursing practice. The panel found that the training courses appear to be limited. There is no training or reflection on the infection prevention and control.

The panel took into account your reference dated 24 October 2024. The panel found this reference of limited value. The author of the reference comments that your *'paths would occasionally cross'* and that you did not work together *'per se'*. The reference does not detail how you have strengthened your practice following the allegations of your misconduct. The panel determined that given the limited insight and lack of evidence of strengthening of practice, that there remains a high risk of repetition. As such, whilst the panel had no reason to think you could not practise kindly, they were not satisfied that you could practice *'safely and professionally'* at present. 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.

The panel determined that a finding of impairment on public interest grounds is also required. In considering the nature of your failings, which included fundamental nursing practice relating to infection prevention and control, medication administration and documentation and record keeping, there was a need to uphold proper standards of behaviour and maintain public confidence in the profession. The panel concluded that members of the public would be concerned if such a finding were not made. Specifically, the panel felt that misconduct of this nature, which has not been remediated, could lead to patients not seeking medical treatment or members of the public being concerned about the care and well-being of vulnerable and or elderly relatives.

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

Sanction

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

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

Submissions on sanction

Mr Hoskins informed the panel that in the Notice of Hearing, dated 12 September 2024, the NMC had advised you that it would seek the imposition of a conditions of practice order with review for 12 months if it found your fitness to practise currently impaired. Mr Hoskins submitted that the deficiencies in your practice (although putting patients at risk) are remediable. He referred the panel to the relevant NMC guidance.

Mr Hoskins highlighted the aggravating features of this case:

- Pattern of misconduct which occurred over a period of time at two different care settings.
- Conduct which placed people receiving care at risk of suffering harm.

Mr Hoskins addressed the different type of sanctions available to the panel. He submitted that taking no further action would not be appropriate given that the panel has found that there is a continued risk to patient safety and undermining of the public's trust in the profession. He submitted that a caution order would not be appropriate because of the risks identified and that the misconduct in this case is not at the lower end of the spectrum of fitness to practise. He submitted that restrictions are required for a safe return to practise.

Mr Hoskins informed the panel that the last interim review hearing order took place on 5 December 2024 (and subsequently extended by the High Court). He submitted that an interim conditions of practice order was in place and referred the panel to the conditions outlined within the interim order review hearing.

Mr Hoskins submitted that a conditions of practice order would be the most appropriate sanction and outlined the relevant NMC guidance. He submitted that there was no evidence of deep-seated attitudinal issues, and that the incidents, although they demonstrate a pattern of behaviour, had to be considered in the context of a long career without complaint raised about your practice. He submitted that there are identifiable areas of practice that can be remediated, such as administration of medicines and infection prevention and control. He submitted that, arguably, medicine administration could be considered too broad however record keeping is *"part and parcel of evidence of medicines administration issues more widely".*

Mr Hoskins also submitted that there is no evidence of general incompetence. The panel has been provided with two training certificates which they found were not targeted to the areas of concerns; however he submitted that this demonstrates a willingness to positively retrain and you confirmed during cross examination that you wish to return to practise as a nurse.

In addressing the conditions that the panel could impose, Mr Hoskins drew the panel's attention to the conditions imposed in the interim order. He provided the panel with a summary of why this was imposed and invited the panel to consider those conditions as a starting point and amend these to manage the risks identified by this panel. Mr Hoskins submitted that the panel may wish to include conditions that address the concerns regarding infection prevention and control and tailor conditions which address the other risks identified by the panel.

Mr Hoskins submitted that a suspension order would go further than is necessary, and there is no evidence of deep-seated attitudinal issues and no evidence of repetition though

you have not worked as a nurse since the referral. The risk identified can be adequately manged with conditions. Mr Hoskins further submitted that 12 months is appropriate to enable your progress to be monitored and assessed.

The panel also had regard to Mr Shadenbury's submissions. He outlined the mitigating factors:

- There are no previous regulatory or disciplinary findings against you.
- You demonstrated remorse for your actions.
- You have undertaken some aspects of training, notably in medication administration.
- Personal mitigation factors:
    - In respect of charges 1 and 2, you felt uncomfortable and overwhelmed when you were working at the Trust.
    - The incidents took place during the global pandemic that ultimately had a significant impact on nurses and staff.
    - Your state of mind was affected by these factors, and as such your clinical practice was impacted and you were unable to perform to your usual standards as an experienced nurse of some 29 years.
    - In respect of Charge 6, you suffered a car accident before the shift, which had an adverse impact on your ability to carry out your duties.

Mr Shadenbury submitted that it is accepted that the panel is likely to determine that taking no action would be inappropriate in view of the deficiencies in your practice which need to be addressed before you can be considered safe to practise. He submitted that equally, the panel is unlikely to consider the imposition of a caution order is appropriate given the public protection issues identified.

In respect of conditions of practice, Mr Shadenbury submitted that the panel can formulate conditions that are both practicable and workable given the misconduct identified in this case.

Mr Shadenbury submitted that a conditions of practice order is a suitable sanction based upon a number of factors:

- There is no evidence of harmful deep-seated personality or attitudinal problems.
- There are identifiable areas of your practice in need of assessment.
- No evidence of general incompetence.
- Potential and willingness to respond positively to retraining.
- The patients will not be put in danger as a result of the conditions, as these conditions will protect patients during the period they are in force where conditions can be created that can be monitored and assessed.

Mr Shadenbury submitted that in respect of record keeping and infection prevention and control, the panel may be minded to impose a condition which requires a further reflective statement from you to address the impact that your actions could have had on vulnerable patients.

Mr Shadenbury submitted that a conditions of practice order is the most appropriate and proportionate sanction, allowing you to demonstrate to a future panel that your insight has fully developed and you can gain employment where you will be able to remediate the concerns found proved and evidence a period of safe practice.

Mr Shadenbury submitted that a period of 12 months would be adequate. He submitted that this would also mark the seriousness of the misconduct and the importance of maintaining public confidence in the nursing profession and uphold proper professional standards.

Mr Shadenbury also referred the panel to the conditions contained within the interim conditions of practice order. He submitted that you should not be limited to a single substantial employer and you would like the panel to consider allowing you to work for a nursing agency. You worked via a nursing agency in the interim period between charges 1

and 2 and charge 6 without further incidents. He therefore asked the panel to consider allowing you to work for a nursing agency.

In addressing the condition which relates to supervision of administration of medication until you are deemed competent, Mr Shadenbury submitted that the charges found proved relate to record keeping and infection prevention and control rather than administration of medication and should be amended accordingly.

Furthermore, Mr Shadenbury submitted that a condition which requires a discussion around general conduct and competence within the workplace is not necessary. He submitted that the other conditions would address the concerns regarding record keeping and infection prevention control.

Mr Shadenbury submitted that a suspension order is neither appropriate nor proportionate given that the panel has determined that your misconduct is capable of remediation. He submitted that you have some insight into your conduct, and you had a previously unblemished career. For these reasons, he invited the panel to impose a conditions of practice order.

Decision and reasons on sanction

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

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

The panel took into account the following aggravating features:

- Conduct which put people receiving care at risk of suffering harm.

The panel also took into account the following mitigating features:

- No previous disciplinary findings.
- Some insight and some remorse shown.
- You acknowledged that you required training and have undertaken some training.

The panel did not consider that the charges amounted to a pattern of misconduct sufficient to be described as an aggravating factor and noted that it had heard limited evidence about the impact of a car crash upon your conduct in respect of charge 6 and there was no evidence that you considered yourself to be unfit for work contemporaneously on the day in question.

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

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

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

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

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that these incidents were relatively isolated episodes of misconduct. The panel noted that you previously had an unblemished career for a significant number of years. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case. A conditions of practice would sufficiently address the public protection concerns and the wider public interest consideration.

Having regard to its findings, 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. In addition, the panel considered such an order would support you in returning to safe practise.

When formulating conditions, the panel noted that record keeping is a fundamental part of the administration of medications.

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 only work for a single substantive employer which must not be via a nursing agency or nursing bank.
>
> 2. When involved in the administration of medicines, you must be directly observed by another registered nurse at all times until you are assessed as competent to do so independently by your employer. Evidence of the successful completion of this assessment must be sent to the NMC within 7 days of completion.
>
> 3. You must ensure that you are supervised by another registered nurse any time you are working. Your supervision must consist of working at all times on the same shift but not always directly observed by another registered nurse.
>
> 4. You must have monthly meetings with your line manager, mentor or supervisor to discuss your practice specifically in relation to medication administration, and infection prevention and control.

5. You must send your case officer a report from your line manager, mentor or supervisor addressing your practice in relation to medication administration and infection prevention and control prior to any NMC hearing.

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 employers you apply to for work (at the time of application).
   c) 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 12 months with review.

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

Any future panel reviewing this case would be assisted by:

- A reflective piece focusing on infection prevention and control and record keeping in relation to administration of medicines.
- Up-to-date testimonials of any work undertaken.
- Certificates of any further training undertaken.

This will be confirmed to you 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 your own interests until the conditions of practice sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Hoskins. He submitted that based on the substantive order made by the panel today, and the risks identified in your case, he invited the panel to impose an interim conditions of practice order for 18 months.

Mr Hoskins submitted that the basis of his application for an interim conditions of practice order is based on the panel's earlier findings. He submitted that this is necessary to protect the public and to cover the period of appeal should you wish to make an application.

Mr Shadenbury told the panel that he had nothing to add further and submitted that this is a matter entirely for the panel to consider.

Decision and reasons on interim order

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

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 protect the public, satisfy the wider public interest and cover the period of 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 you are sent the decision of this hearing in writing.

That concludes this determination.