# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Meeting**
**Thursday 27 – Friday 28 March 2025**

Virtual Meeting

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| **Name of Registrant:** | Melanie Hayworth | |
| **NMC PIN:** | 11E0711E | |
| **Part(s) of the register:** | Registered Nurse – Sub Part 1<br>Adult Nurse L1 – 22 December 2011 | |
| **Relevant Location:** | Wiltshire | |
| **Type of case:** | Misconduct | |
| **Panel members:** | Darren Shenton<br>Georgina Wilkinson<br>Jennifer Childs | (Chair, lay member)<br>(Lay member)<br>(Registrant member) |
| **Legal Assessor:** | Gerard Coll | |
| **Hearings Coordinator:** | Shela Begum | |
| **Facts proved:** | Charges 1b, 1b, 1c(i and ii) and 1d | |
| **Facts not proved:** | None | |
| **Fitness to practise:** | Impaired | |
| **Sanction:** | **Conditions of practice order (18 months)** | |
| **Interim order:** | **Interim conditions of practice order (18 months)** | |

**Decision and reasons on service of Notice of Meeting**

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mrs Hayworth's registered email address by secure email on 17 February 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was scheduled to be heard virtually.

In the light of all of the information available, the panel was satisfied that Mrs Hayworth has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

**Decision and reasons to proceed as a meeting**

The panel considered whether, in all of the circumstances, including the evidence of Mrs Hayworth's non-engagement with the NMC leading up to this hearing, it should proceed to hear and resolve this case on the papers alone. The panel was reminded that the NMC does not invite panels to consider this issue in substantive meetings.

The panel accepted the legal assessor's advice. The panel recognised that it had an obligation to conduct hearings in a way that was consistent with fairness for all parties.

In GMC v Adeogba and GMC v Visvardis [2016] EWCA Civ 162, the Court of appeal reminded panels that the discretion to proceed in the absence of a registrant should only be exercised with caution and with regard to avoiding the potential for injustice. However, a panel should not allow the regulatory process to be frustrated by wilful disregard of the process by the registrant concerned. A registrant's right to be present and participate in a

hearing into her fitness to practise must be weighed against the duty of regulatory bodies to conduct a robust and timely investigatory process in the public interest.

The panel observed a copy letter to Mrs Hayworth dated 17 February 2025 informing her that on 22 January 2025, a panel had decided that the matter should be resolved at a meeting. The panel had no information to suggest that Mrs Hayworth had responded asking for that decision to be reviewed or stating that she now wished to participate in the process.

In all of the circumstances, the panel decided that there was no real purpose to be served by a delay in this matter being resolved and that there were no issues which, on reading the papers, that it could not resolve without being able to ask questions of a case presenter for the NMC. Accordingly, the panel decided to deal with the matter as a meeting.

**Details of charge**

That you a Registered Nurse;

1. Made medication errors on the following dates.
    a) On 11 November 2020 Administered Patient A with adrenaline instead of a flu vaccination
    b) On 20 February 2021 Administered the lower dose of 5mg of Morphine Sulphate over 24 hours instead of 30-100mg, as prescribed to Patient B.
    c) Documented on the drug chart P3, for Patient C administering 10 mg of midazolam instead of the required dosage of 20mg on;
        i. 16 June 2021
        ii. 17 June 2021
    d) On 28 February 2022 applied steroid cream to Patient D in the absence of viewing a prescription and/or correct paperwork.

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

**Background**

The NMC received a referral on 22 June 2022 from Wiltshire Health and Care concerning Melanie Hayworth, a Band 5 Community Nurse, based on incidents that occurred between 11 November 2020 and 28 February 2022.

It is alleged that Mrs Hayworth made an error on 11 November 2020 during a home visit when she administered adrenaline instead of the flu vaccine. The flu vaccine and adrenaline were stored in the same cool-box, and the adrenaline was incorrectly administered, which led to a serious incident due to an increased pulse rate in the patient. Following this, Mrs Hayworth was placed on a Performance Improvement Plan after attending training on 23 November 2020.

It is further alleged that on 20 February 2021, Mrs Hayworth under-dosed morphine sulphate in a syringe driver. She allegedly referred to a prescription that had already been superseded, resulting in an incorrect dose being administered. This error was discovered by a colleague when reviewing the patient's notes, prompting additional training in medication administration and syringe driver use in May 2021.

Additionally, it is alleged that despite receiving relevant training, Mrs Hayworth under-dosed midazolam on two occasions, 16 and 17 June 2021. On 16 June 2021, Mrs Hayworth recorded the correct dose of 20mg, but later documentation stated only 10mg had been administered, which was incorrect.

It is also alleged that on 28 February 2022, Mrs Hayworth applied steroid cream to a patient's leg when it was not authorised to be administered.

Mrs Hayworth resigned from her position on 15 March 2022.

**Decision and reasons on facts**

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

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

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

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

- Witness 1: Community Team Manager, Wiltshire Health and Care

The panel has received no evidence from Mrs Hayworth as she has not engaged in these regulatory proceedings at all.

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

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

**Charge 1a**

1. Made medication errors on the following dates.
a) On 11 November 2020 Administered Patient A with adrenaline instead of a flu vaccination

**This charge is found proved.**

In reaching this decision, the panel took into account the witness statement of Witness 1, the Concise Investigation Report which included Patient A's nursing notes and Mrs Hayworth's own reflective account prepared as part of the local investigation:

The panel noted that Witness 1 stated:

*"Melanie visited a 38-year-old patient having treatment for bowel cancer who needed their central line cared for and flushed. The patient was also booked for a flu vaccination. This incident contributed to an acceleration in organisational*

*change, where adrenaline is now carried in a separate locked box to any other injection that is going to be administered."*

The panel had regard to the Concise Investigation Report which set out the chronology of events as taken from the Datix report which set out:

*"I was attending a patient to change her Picc line dressing and flush the Picc line as well as administer her flu vaccine. I attended to the Picc line and then went to get the flu vaccine out of the cool box that it had been transported in. I wrongly believed that there was only the flu vaccination in the top layer of the cool box. I wrote the LOT number and expiry date on the completed health questionnaire and administered the injection. The patient then said she felt unwell and her face became pale and her respirations became faster. I took her pulse and her heart was racing […]"*

The panel took into account the registrant's own admission and reflective statement, which indicated a clear acknowledgment of the mistake. In her account, she stated:

*"Attended a patient for Picc line care and to administer her flu vaccine. The vaccine was transported into the house in a cool box which contained the vaccine and adrenaline to use in the instance of a anaphalaxis. I performed the Picc line care and then went into the cool box to retrieve the flu vaccine. I wrote the expiry date, and the LOT number on the health safety paperwork and commenced the administration. Immediately the patient said that she felt unwell. Her face became pale and her respirations became faster, and she became tachycardic. I believed that the patient was having an adverse reaction to the vaccine and went to get the adrenaline out of the cool box. It was at that point that I realised my terrible mistake. I believed that the adrenaline was on the bottom of the cool box separate to the vaccine but it had been in the same section of the box and I had administered the adrenaline instead of the flu vaccine. I attempted to keep calm in front of the patient while explaining that I had made a horrendous drug error. I then ran down to use her mothers phone for an ambulance and had to explain the same to her. I returned to the patient and rang the ambulance. At this point the patient was beginning to improve, her breathing was becoming slower and she was less tachycardic.[…]"*

The panel also had regard to the patient notes where the incorrect drug administration was recorded.

The panel was satisfied that the investigation report, Witness 1's statement and your account all provided a clear outline of what occurred during the incident.

Additionally, the panel noted that Mrs Hayworth promptly followed the correct post-incident procedures, including adhering to the duty of candour by immediately reporting the mistake. However, these actions did not alter the fact that the adrenaline was administered incorrectly. Given Mrs Hayworth's admission, the supporting documentation, and the clear potential risk of harm, the panel found this charge proved.

**Charge 1b**

1. Made medication errors on the following dates.
    b) On 20 February 2021 Administered the lower dose of 5mg of Morphine Sulphate over 24 hours instead of 30-100mg, as prescribed to Patient B.

**This charge is found proved.**

In reaching this decision, the panel took into account Witness 1's witness statement, the patients record and drug chart, the local Investigation Report and the Mrs Hayworth's local interview.

The panel noted that within her written statement, Witness 1stated:

> *"This patient was on a syringe driver and Melanie administered an incorrect dose of Morphine Sulphate. She referred to a prescription that had since been superseded. The patient had been increased from 5mg Morphine Sulphate over 24 hours to 30-100mg over 24 hours. Melanie said she didn't realise this had happened. She used the previous lower dosage of 5mg from the previous day when the prescription had changed to a minimum of 30mg over 24 hours. The*

*higher dosage prescription was also in the house, but Melanie did not use it. I produce a file note made following the meeting with Melanie:"*

The panel had regard to the patient's drug chart which confirmed the expected dosage versus the administered dosage of Morphine Sulphate.

The panel took into account the local interview with Mrs Hayworth where she initially indicated that she had checked the prior day's dosage but felt the patient did not need the increased amount. The panel noted that the interview notes stated:

*"Discussion had with Mel on the questions raised within the Datix*

*Mel stated she had administered 5mg (within the driver) on 20/2/21 referring to P2 from 18/2/21 which in this case it was in line with P2 however not consistent with the dose that had been given the day before on 19/2/21 30mg (another P2 was in the house).*

*She did check what had been administered the day before however she said that she did not feel that the patient needed it and decided to go by the dose on the 18/2/2021.*

*• Administration of medicine did not cause patient harm. Patient was end of life however the P2 stated 30 mg and was not followed as prescribed.*

*In reflection Mel stated she should have discussed with another member of staff or triage nurse.*

*Taken P2 out of home that had the lower dose to avoid confusion"*

The panel considered that the error involved administering 5mg of Morphine Sulphate instead of the prescribed 30mg, following an increase in the patient's prescription and that the mistake was discovered the next day when a colleague reviewed the drug chart. The panel noted there was some conflicting evidence around whether Mrs Hayworth made a deliberate decision to administer the lower dose or whether this was an error rather than a clinical decision. However, the contemporaneous records, including the investigation findings and witness statements, indicated that the incorrect dosage resulted from an error rather than a clinical judgment.

The panel also noted that two separate drug charts were in the patients property at the time, containing both the 5mg prescription and the updated 30 – 100mg prescription, contributing to the confusion. The Incident Review form cited staffing shortages and

increased workload as contextual factors. However, despite these mitigating circumstances, the evidence demonstrated that the incorrect dose was given, and the charge was therefore found proved.

**Charge 1c (i and ii)**

> 1. Made medication errors on the following dates.
> c) Documented on the drug chart P3, for Patient C administering 10 mg of midazolam instead of the required dosage of 20mg on;
> i. 16 June 2021
> ii. 17 June 2021

**This charge is found proved.**

In reaching this decision, the panel took into account the patient drug charts, the patient notes, Witness 1's witness statement

The panel noted that in her witness statement, Witness 1stated:

> *"On 16 June 2021, Melanie documented that she administered into the syringe driver 20mg of Midazolam which was the correct dose for this patient. However, on 16th and 17th June 2021, Melanie documented on the drug chart (a P3 which is a record of administration) that she only administered 10mg on both days. The reason for Melanie's conduct is unclear to me. I do know that she was very busy that day. Melanie was given a 3rd syringe driver patient to attend that day. The triage nurse had phoned Melanie (who already had 2 patients needing syringe driver replenishments to attend) to ask her to visit a 3rd patient. The reason was due to lack of staff capacity. We try and keep this at a maximum of 2 patients on syringe drivers it due to the complexity of these visits and the emotional toll of dealing with end-of-life patients. I have attached an incident form that Mel completed at the time of the incident to demonstrate the high volume of patients and low capacity to perform visits that day."*

The panel considered the evidence presented, which included the patient's notes and the patient's drug chart. The panel noted that on 16 and 17 June 2021, there were discrepancies between the recorded dosage in the patient's notes and the dosage documented in the drug chart. Specifically, the panel observed that the patient's notes accurately reflected the correct dose of 20mg of midazolam, whereas the entries in the drug chart for both 16 and 17 June 2021 indicated that only 10mg was administered.

After reviewing the evidence, the panel concluded that Mrs Hayworth made a medication administration error by documenting an incorrect dose of 10mg on the drug chart on both occasions, instead of the required 20mg. The panel considered the fact that the patient's notes contained the correct dosage, suggesting that Mrs Hayworth may have intended to administer the correct amount, but made an error in the documentation process. Accordingly, this charge is found proved.

**Charge 1d**

> 1. Made medication errors on the following dates.
> d) On 28 February 2022 applied steroid cream to Patient D in the absence of viewing a prescription and/or correct paperwork.

**This charge is found proved.**

In reaching this decision, the panel took into account Witness 1's Witness Statement in which she stated:

> *"During this incident Melanie applied a steroid cream to a patient's leg when it was not permitted to administer this medication.*
>
> *[…]*
> *But Melanie said clearly that she was called and asked to pick up the patient's steroid cream from the surgery and apply this to the patient's leg as they couldn't get to the practice. Melanie said there was a permission to administer prescription back in the office to sign when she got back. […]*

*The error was that she administered the steroid cream without the correct prescription, but Melanie said she was also asked to do this by the band 6 nurse who cannot remember the incident and should not have put her in that position. She was asked to collect a cream and go to the patient house to put it on, when her performance plan stated she wasn't to be given any urgent visits to minimise stress and distractions."*

The panel had regard to the Investigation Report which highlighted the concerns raised regarding the fingertip unit dosage discrepancy but contained no account from Mrs Hayworth herself.

Email correspondence and witness statements referenced the registrant's reaction, including comments which suggested a perception of being singled out rather than a dispute over the factual accuracy of the incident.

The panel noted that there was no drug chart available for verification, as the entire dispute revolved around the missing P2 (permission to administer) form. However, the surrounding documentation and witness statements supported the conclusion that Mrs Hayworth acted outside of policy by administering the cream without viewing the prescription or correct paperwork.

The panel determined that the contemporaneous evidence, including the investigation report and witness statements, supported the conclusion that Mrs Hayworth had administered the steroid cream in the absence of viewing a prescription. The panel reviewed the available evidence regarding the administration of steroid cream to Patient D and found the charge proved on the balance of probabilities.

**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 Hayworth'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 Hayworth's fitness to practise is currently impaired as a result of that misconduct.

**Representations on misconduct and impairment**

The panel had regard to the NMC's statement of case in which it stated:

> *"The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:*
>
> > *'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances'.*
>
> *9. As may the comments of Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), respectively*
>
> *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'.*
>
> *And*

*'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.*

*10. Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Nursing and Midwifery Council's Code of Conduct.*

*11. We consider the following provision(s) of the Code have been breached in this case;*

*4 Act in the best interests of people at all times*
*6 Always practise in line with the best available evidence*
*19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice*
*20 Uphold the reputation of your profession at all times*

*12. We consider the misconduct serious because the Registrant has engaged in conduct that placed multiple patients at risk of harm. The Registrant failed to administer the prescribed medications and the prescribed doses on a number of occasions. Her conduct indicates carelessness through her failure to read or check prescriptions and the vaccinations before administering the medication. The Registrant was offered further training and support but continued to make errors. Her conduct fails to adhere to the Code and fails to preserve safety or prioritise patients. The NMC invited the panel to take the view that the facts found proved amount to misconduct."*

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Mrs Hayworth's fitness to practise impaired. In its statement of case, the NMC stated:

*"13. The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. 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?"*
*14. If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.*
*15. Answering this question involves a consideration of both the nature of the concern and the public interest. In addition to the following submissions the panel is invited to consider carefully the NMC's guidance on impairment.*
*16. When determining whether the Registrant's fitness to practise is impaired, the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions were:*
*1. has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
*2. has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*
*3. has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or*
*4. has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.*
*17. It is the submission of the NMC that the first three questions can be answered in the affirmative in this case.*
*18. Impairment is a forward thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.*
*19. We consider the Registrant has displayed no insight. We take this view because*

*there has been no formal response to the concerns or any reflections provided by the Registrant.*

*20. We have considered the fact that the Registrant received further support and training at the time of the incidents but there is no evidence of any further training being undertaken between the events occurring and present.*

*21. We note the registrant has not worked since the issues of concern. The Registrant resigned before the Trust could undertake a formal investigation*

*22. We consider there is a continuing risk to the public due to the Registrant's lack of full insight and remediation. There is also no evidence to demonstrate strengthened practice through work in a relevant area*

*Public interest*

*23. In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:*

*"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."*

*24. Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.*

*25. In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which hasn't been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.*

*26. However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.*

*27. We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. The Registrant's conduct engages the public interest because her conduct resulted in harm. Administration of medication is central to a nurse's role and a repeated failure to do so safely and correctly would alarm the public and result in a loss of confidence in the profession."*

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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (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 Mrs Hayworth's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Hayworth's actions amounted to a breach of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code"). Specifically:

**10 Keep clear and accurate records relevant to your practice**
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
**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
**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**

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

**18.3** make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

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

**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**

**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 has thoroughly considered the evidence and the details surrounding the allegations against Mrs Hayworth, focusing on whether each incident constitutes misconduct individually, and whether, when considered together, they amount to misconduct. The panel applied the relevant guidance, particularly taking into account whether the actions in question would be deemed “deplorable” by fellow professionals, as well as the broader implications for public confidence and patient safety.

In relation to charge 1a which concerns the administration of an incorrect drug, which resulted in a patient suffering a reaction. The panel found that Mrs Hayworth failed to properly check the ampoule before administration, despite clear guidance that verifying medications is a fundamental duty. The ampoules of the intended and incorrect drugs were visually distinct, making the mistake both unexpected and avoidable. Mrs Hayworth herself admitted that she did not follow standard medication-checking procedures. The patient experienced significant consequences, including a need for urgent intervention and

contacting emergency services. However, the panel also took into account that Mrs Hayworth took immediate and appropriate corrective action upon realising her mistake and displayed professionalism by disclosing the error to the patient and her manager. Additionally, she was working under considerable pressure and distraction at the time, which included the presence of family members, potentially contributing to the error.

While this was a serious medication error, the panel must consider whether it meets the threshold for misconduct. Given Mrs Hayworth's immediate corrective actions and the mitigating circumstances, the error could be seen as a mistake as a result of human error rather than misconduct. The panel concluded that it was a significant error, but ultimately a mistake. It considered that, particularly in light of Mrs Hayworth's response to the situation, fellow colleagues would not consider this conduct deplorable. It determined that, on its own, this charge did not amount serious professional misconduct.

In relation to charge 1b, the panel noted that there was the presence of two drug charts in the patient's home which potentially led to confusion. It considered that, whilst Mrs Hayworth should have verified the correct prescription, she mistakenly relied on an outdated one. The panel considered that the existence of multiple drug charts was poor practice and there was a systemic failure to remove outdated drug charts from circulation. Additionally, Mrs Hayworth was working in conditions of high workload and staffing shortages, which contributed to the likelihood of such an error occurring. Importantly, the error did not appear to cause direct harm to the patient, though it did have the potential to do so. On balance, the panel does not find that, on its own, this incident amounts to serious professional misconduct. The circumstances suggest that this was a human error, exacerbated by systemic issues, rather than a significant professional failing.

In relation to charge 1c the panel recognised the importance of accurate documentation for patient safety and acknowledges that such errors can lead to future medication mistakes. However, the panel noted that this was an administrative error rather than one of negligence or recklessness. The working conditions, including patient complexity and workload, may have contributed to the mistake. Despite the potential risks such documentation errors pose to patient safety, the panel did not consider this administrative mistake, taken on its own, to constitute serious professional misconduct. However, it is

acknowledged that errors of this nature have the potential to impact patient safety, and Mrs Hayworth should be mindful of the need for accuracy in documentation.

In relation to charge 1d, the panel considered that without the required P2 form in hand Mrs Hayworth relied on a verbal instruction from a senior nurse. The key issue here is the importance of following proper prescribing and documentation procedures, especially when it comes to medication administration. There is a clear risk to patient safety when medication is administered without the proper authorisation. The panel considered that Mrs Hayworth was acting in good faith, following what she believed to be an instruction from a senior colleague. The panel finds that, while this incident was not procedurally correct, on its own it did not amount to serious professional misconduct.

Having considered each charge individually, the panel considered whether collectively Mrs Hayworth's actions amounted to serious professional misconduct. The panel considered that there had been repeated errors between November 2020 and February 2022. It considered that the errors indicated a concerning pattern of conduct relating to Mrs Hayworth's medication administration rather than isolated incidents. Despite Mrs Hayworth being placed on personal improvement plans and receiving additional training after each error, she continued to make further medication-related mistakes. A reasonable expectation is that, after an error and additional training, Mrs Hayworth, as a registered nurse, would be particularly cautious to avoid making further mistakes. The cumulative nature of these errors, despite interventions, indicates a lack of adherence to fundamental nursing responsibilities, particularly regarding medication safety.

While it could be argued that the individual incidents, if isolated, might not meet the threshold for serious professional misconduct, the cumulative pattern led the panel to determine that this amounts to serious professional misconduct. Mrs Hayworth's repeated failure to ensure patient safety, despite multiple interventions, demonstrates a significant concern regarding her professional responsibility. The panel found that, collectively, Mrs Hayworth's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious professional misconduct.

**Decision and reasons on impairment**

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

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

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

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

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

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

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

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

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

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

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

d) *[…].'*

The panel determined that limbs a – c of the 'test' are engaged in this case. The panel found that patients were put at risk of harm as a result of Mrs Hayworth's misconduct. Mrs Hayworth made multiple medication-related errors, some of which resulted in harm to patients, including adverse reactions and discomfort. Despite receiving training and performance improvement plans, these errors continued, demonstrating a failure to maintain safe medication practices.

The panel considered that Mrs Hayworth's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It determined that the repeated nature of the errors raises concerns about Mrs Hayworth's professional attitude towards her mistakes. Despite multiple interventions and training, these errors persisted, which could be seen as a failure to uphold the standards expected of a registered nurse.

Regarding insight, the panel considered that while Mrs Hayworth initially demonstrated insight and remorse following her first error, including proposing corrective actions and engaging in further training, this insight has not been sustained. The fact that she continued to make errors, without demonstrating ongoing reflection or improvement,

indicates that she has not consistently upheld the fundamental tenets of the profession. Mrs Hayworth has not engaged with her regulator throughout these proceedings. The panel has not had evidence before it to demonstrate that Mrs Hayworth understands how her actions continued to place patients in her care at a risk of harm, how this impacted negatively on the reputation of the nursing profession or how she would handle the situation differently in the future.

The panel was satisfied 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 Hayworth has taken steps to strengthen her practice. The errors in this case are remediable through training, reflection, and the strengthening of practice. The panel noted that initially Mrs Hayworth did engage in further training and participated in improvement plans after the first few errors. However, the errors continued, suggesting that these efforts were either not effective or not maintained. There is no up-to-date evidence of her current understanding of these issues, nor is there any indication that she has reflected on or addressed her failures. Mrs Hayworth has disengaged from the regulatory process, which makes it difficult to assess whether she has made any lasting improvements.

In light of this, the panel concluded that there remains a risk of repetition. This conclusion is based on the continued occurrence of medication errors despite previous interventions, including training and performance improvement plans. Furthermore, Mrs Hayworth has shown a lack of sustained improvement and has disengaged from the regulatory process, with no evidence of recent reflection or remediation.

For all of the reasons above, the panel determined that a finding of impairment is necessary on public protection grounds.

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

The panel determined that a finding of impairment on public interest grounds is required because a reasonable member of the public, upon learning of these repeated errors, could reasonably have concerns about allowing Mrs Hayworth to continue to practise without restriction, particularly when a registered nurse has not engaged at all with the regulatory proceedings. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Hayworth's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Hayworth's 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 18 months. The effect of this order is that Mrs Hayworth'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. The panel accepted the advice of the legal assessor.

**Representations on sanction**

In the NMC's statement of case, they submitted:

> *"28. We consider a Conditions of practice order is an appropriate and proportionate sanction in this case.*
> *29. The aggravating factors noted by the NMC are that the errors occurred on four separate occasions despite further training as well as the lack of insight and remediation.*
> *30. The Registrant has no previous concerns and referrals which the NMC notes as a mitigating factor.*

*31. Having considered our sanctions guidance, the NMC submits that this case is too serious for the Panel to take no action or impose a Caution Order. This is a case that involves issues in the Registrant's clinical practice, issues which the NMC take the view can be remediated. A Conditions of Practice Order would allow the Registrant the opportunity to work supervised, undertake further training and strengthen her practice.*

*32. A Suspension Order and Strike Off would not be appropriate given the conduct can be remediated and is not entirely incompatible with remaining of the register."*

**Decision and reasons on sanction**

Having found Mrs Hayworth'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 engagement in these proceedings
- 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:

- Apologies or evidence of some initial insight
- Challenging working conditions as a result of the Covid-19 pandemic which including overloading and staff shortages
- Personal mitigation including indications of personal hardship

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 Hayworth'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 Hayworth'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 Hayworth'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:

- *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;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *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 failings identified,

while serious, primarily relate to medication administration errors, which are remediable through targeted training, supervision, and a structured approach to reflection. These are areas in which practical improvements can be made, and conditions can be tailored to address specific gaps in Mrs Hayworth's practice.

Additionally, Mrs Hayworth has previously engaged with training and performance improvement plans, showing some willingness to address the issues with her practice. Although the improvements were not sustained, there is evidence that, if she re-engaged, she could potentially improve with the appropriate support and guidance. The panel concluded that conditions of practice could be put in place to ensure ongoing supervision and reflection, enabling her to further develop and strengthen her practice. While there is a risk of repetition, this risk can be mitigated through conditions that ensure close monitoring of her practice, ensuring patient safety is not compromised while providing her with the opportunity to remediate.

Moreover, a conditions of practice order would be a proportionate response, allowing Mrs Hayworth to continue practising under clear conditions that address the identified concerns while protecting patient safety. The panel concluded that a conditions of practice order would provide a constructive and supportive framework for her to improve and re-engage with the regulatory process.

Furthermore, the panel was satisfied that a conditions of practice would balance public protection with Mrs Hayworth's ability to return to practice in a safe and regulated manner, safeguarding patients from further errors while maintaining public confidence in the profession. The panel was of the view that it was in the public interest that, with appropriate safeguards, Mrs Hayworth 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 Mrs Hayworth's case because, although there have been repeated medication errors, these errors were not made with intentional harm or gross negligence. The panel

acknowledges that there were mitigating factors, including high workload and environmental pressures, which contributed to the mistakes. Furthermore, Mrs Hayworth has previously shown some insight into her errors and has engaged in training and improvement plans. While there remains a risk of repetition, the panel considers that Mrs Hayworth may be able to remedy her practice with further support and reflection, rather than immediate removal from the register. At this stage, a suspension or striking-off order would not provide the opportunity for remediation and professional development.

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 not manage or administer medication unless you are directly supervised by another registered nurse until you have been assessed and signed off as competent to do so independently.
>
> 2. You must send your case officer evidence that you have successfully completed a medications management and administration competency assessment.
>
> 3. You must work with your line manager, supervisor or mentor to create a personal development plan (PDP). Your PDP must address the concerns about your medications management and administration. You must:

a) Send your case officer a copy of your PDP prior to any review of your case.
b) Send your case officer a report from your line manager, supervisor or mentor prior to any review of your case. This report must show your progress towards achieving the aims set out in your PDP.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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 18 months. The panel concluded that this period of time would allow sufficient time for Mrs Hayworth to re-engage with the process, obtain nursing employment and give her an opportunity to demonstrate that she has taken the required steps towards her return to safe and unrestricted nursing practice.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mrs Hayworth 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:

- Your engagement and attendance
- Evidence of professional development, including documentary evidence of completion of any training undertaken by you
- Testimonials from a line manager or supervisor that detail your current work practices
- A statement from you which addresses your insight into the misconduct
- Information from you indicating your future intentions with regards to your nursing practice.

This will be confirmed to Mrs Hayworth 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 Hayworth's own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

**Representations on interim order**

The panel took account of the representations made by the NMC which stated:

> *"33. If a finding is made that the registrant's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
> *34. If a finding is made that the registrant's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registrant we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest."*

**Decision and reasons on interim order**

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

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 Hayworth is sent the decision of this hearing in writing.

That concludes this determination.