Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 13 October 2025 – Wednesday, 5 November 2025

Virtual Hearing

Name of Registrant:	**Penelope Claire Wright**
NMC PIN:	83Y2406E
Part(s) of the register:	Registered Nurse – Sub Part 2 Adult Nursing (Level 2) – 06 August 1985 Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 24 September 1994 Renal Nursing (P136) – 09 August 1995
Relevant Location:	Nottinghamshire
Type of case:	Lack of competence
Panel members:	Simon Banton (Chair, Lay member) Claire Cawley (Registrant) Lorraine Wilkinson (Lay member)
Legal Assessor:	Graeme Henderson
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by Sahara Fergus-Simms, Case Presenter
Miss Wright:	Present and represented by Darren Finnegan, instructed by the Royal College of Nursing (RCN)
No case to answer:	**Charges 3a, 3b and 3c**
Facts proved by admission:	**Charges 4 and 5a(iv)**
Facts proved:	**Charges 1a), 1b), 1c) 1d) 1e) 1f) 1g) 1h) 1i), 2a)**

	2b) 2c), 5a(i) 5a(ii), 5a(iii), 5c), 5d(i), 5d(ii), 5d(iv), 5d(v), 5d(vi), 5d(vii), 5e(i), 5e(ii), 5e(iii), 5f(i), 5f(ii), 5f(iii), 5f(iv), 5g(i), 5g(ii), 5g(iii), 5g(iv), 5g(v), 5h(i), 5h(iii), 5h(iv) and 5h(v)
Facts not proved:	**2d), 5b(i), 5b(ii), 5d(iii), 5h(ii),**
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (12 months) – with review**
Interim order:	**Interim suspension order (18 months)**

Details of charges (as read)

That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a dialysis nurse in that you:

1) Between 29 November 2021 and 1 November 2022 while subject to an action plan and/or informal capability process/informal performance improvement programme failed to meet the following objectives:

    a) Delivery of Patient Care.
    b) Hand Hygiene and infection control.
    c) Waste segregation.
    d) Prioritising workload.
    e) Providing patient dialysis in accordance with individual dialysis prescription.
    f) Providing individual patient care.
    g) Treating colleagues with respect.
    h) Medication management.
    i) Safety checks.

2) Between May 2022 and 16 November 2022 in respect of Patient 7:
    a) On one or more occasion pulled/tugged their neck line.
    b) On one or more occasion did not refrain from pulling/tugging their neck line after being told by them that it caused discomfort/pain.
    c) On a date unknown inserted a swab into rather than around their neck line.
    d) On an unknown date wrongly applied a gel dressing despite them advising you they were allergic to gel dressings.

3) Between May 2022 and 16 November 2022 in respect of Patient 6:
    a) On one or more occasion pulled/tugged their neck line.

b) On an unknown date covered their face with a plastic sheet rather than placing the sheet under their chin.
c) On an unknown date did not administer their required medication.

4) On 1 July 2022 failed to administer to Patient 14 Enoxaparin.

5) Between 3 November 2022 and 16 November 2022 while subject to a formal capability process/formal performance improvement plan you:

a) On 11 November 2022 in respect of Patient 2:
i. Did not prepare the dialysis machine prior to them attending.
ii. Delayed starting their dialysis treatment by over 50 minutes.
iii. Required to be prompted to remove air/aspirate the syringe/needle containing saline solution.
iv. Did not clamp their line when disconnecting them from the dialysis machine.

b) On 11 November 2022 in respect of Patient 3:
i. Did not wipe down their lines prior to connecting them to the dialysis machine.
ii. Were unable to insert their needle to commence dialysis.

c) On 11 November 2022 handled Patient 5's needle without wearing gloves.

d) On 11 November 2022 and/or 15 November 2022 in respect of an unknown patient/s:
i. Did not check the earth cable was connected properly their dialysis machine/s.
ii. Did not check bed breaks.
iii. Did not compare their pre-dialysis weight and post dialysis weight.
iv. Did not assess for oedema.
v. Did not check shortness of breath.
vi. Did not complete the pre-safety checks.

vii. Did not assess them for Covid-19 signs and/or symptoms.

e) On 11 November 2022 in respect of Patient 9:

i. Required to be prompted remove their clothing to check their blood pressure.

ii. Failed to administer their Enoxaparin.

iii. Required to prompted to sign their medication chart.

f) On 11 November:

i. Did not clean the trolley containing equipment needed to connect patients to dialysis machines.

ii. Did not wash/disinfect your hands between patients and/or cleaning equipment.

iii. Failed to change gloves.

iv. Did not clean up blood left on the floor/bed from previous patient/s.

g) On 14 November 2022:

i. Were unaware that a dialysis machine was not priming.

ii. Did not identify that an unknown patient's arterial line was not connected properly to the dialysis machine.

iii. In respect of Patient 11;

(1) Struggled to insert their needle.

(2) Were unable to calculate their UFgoal.

iv. In respect of Patient 10 wrongly identified that they required their Diafer medication to be administered.

v. In respect Patient 13 did not read their prescription to identify the correct needle size for them.

h) On one or more occasion on dates set out in Schedule A:

i. Failed to dispose of clinical waste appropriately.

ii. Failed to dispose of sharps in sharps bins.

iii. Failed to use a new wipe to clean separate surfaces.

iv. Failed to clean your hands effectively.

v. Did not adhere to the 5 moments of hand hygiene

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

Schedule A

11 November 2022
14 November 2022
15 November 2022

Decision and reasons on application for the hearing to be held in private (Day 4)

Ms Fergus-Simms, on behalf of the Nursing and Midwifery Council (NMC), made a request that the entirety of all patient witnesses' respective oral evidence be heard in private, on the basis that proper exploration of your case involves reference to their respective health matters. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Finnegan, on your behalf, did not oppose the application.

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

The panel decided that the interests of preserving the confidentiality of matters relating to the patient witnesses' health outweighed the public interest in holding such parts of the hearing in public. Accordingly, the panel determined that the hearing be held in private when matters of their respective health are raised in order to keep those matters out of the public domain.

Decision and reasons on application to amend the charge (Day 6)

The panel of its own volition under Rule 28 of the Rules proposed amendments to the charges. This was to rectify an incorrect spelling of a word in the charge 5d(ii); add wording to correct grammatical errors in charges 5d(i), 5d(v), 5e(i), 5e(iii), and add the year of the alleged incident in charge 5f for consistency, as follows:

5) *Between 3 November 2022 and 16 November 2022 while subject to a formal capability process/formal performance improvement plan you:*

   d) *On 11 November 2022 and/or 15 November 2022 in respect of an unknown patient/s:*

      i. *Did not check the earth cable was connected properly **to** their dialysis machine/s.*
      ii. *Did not check bed ~~breaks~~ **brakes***
      iii. *Did not compare their pre-dialysis weight and post dialysis weight.*
      iv. *Did not assess for oedema.*
      v. *Did not check shortness **of** breath.*
      vi. *Did not complete the pre-safety checks.*
      vii. *Did not assess them for Covid-19 signs and/or symptoms.*

   e) *On 11 November 2022 in respect of Patient 9:*

      (i) *Required to be prompted **to** remove their clothing to check their blood pressure.*
      (ii) *Failed to administer their Enoxaparin.*
      (iii) *Required to **be** prompted to sign their medication chart.*

   (f) *On 11 November **2022:***

      (i) *Did not clean the trolley containing equipment needed to connect patients to dialysis machines.*

(ii) Did not wash/disinfect your hands between patients and/or cleaning equipment.

(iii) Failed to change gloves.

(iv) Did not clean up blood left on the floor/bed from previous patient/s.

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

The panel was of the view that amending these typographical and grammatical errors would provide clarity and more accurately reflect the evidence.

The panel determined that such amendments were in the interests of justice. It was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. The panel concluded that it was therefore appropriate to make these amendments to ensure clarity and accuracy of the evidence.

Ms Fergus-Simms and Mr Finnegan did not oppose the application.

Decision and reasons on application to admit the written statement of Patient 6 as hearsay evidence (Day 7)

The panel heard an application made by Ms Fergus-Simms under Rule 31 to allow the written statement and corresponding handwritten complaint document of Patient 6 to the Clinical Management Team at the Fresenius Dialysis Bassetlaw Unit (Clinic 2) to be admitted as hearsay evidence.

Ms Fergus-Simms referred the panel to an email dated 19 October from a relative of Patient 6, who informed the NMC that Patient 6 had passed away on 11 October 2025. She submitted that in these circumstances, the only method in which to bring Patient 6's evidence before the panel is through a hearsay application. She submitted that prior to her passing, Patient 6 had been ready and willing to attend the hearing to give evidence.

Ms Fergus-Simms referred the panel to *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), *Ogbonna v NMC* [2010] EWCA Civ 1216 and *R (Bonhoeffer) v GMC* [2012] IRLR 37.

Ms Fergus-Simms submitted the Patient 6's evidence relates to charge 3 in its entirety and is highly relevant.

She submitted that it would be fair in the circumstances to admit the evidence as hearsay because Patient 6 has now passed away. She submitted that she is not a witness who has disappeared or voluntarily absented themselves from proceedings.

Ms Fergus-Simms took the panel through the key parts of Patient 6's witness statement and referred to a handwritten complaint letter which was referred to in the witness statement. In relation to the veracity of Patient 6's witness statement she submitted that it is corroborated by her local handwritten complaint letter.

In relation to the existence or otherwise of a good and cogent reason for the non-attendance of Patient 6, Ms Fergus-Simms submitted that is an important factor and goes without saying (Patient 6's passing). She submitted that were the panel to allow the application Mr Finnegan will no doubt address in his submissions whether or not the patient witness statements are fabricated. She submitted that all of the witnesses have been vigorously cross-examined by Mr Finnegan on whether their statements consist of lies and they have all refuted that suggestion in no uncertain terms. Furthermore they have been steadfast in rejecting any suggestion that the patient complaints have been made as a result of coercion by Witness 1. She submitted that Witness 1 also makes reference to the care of other patients, including Patient 6 and the reliability of the evidence can be tested in this way.

Ms Fergus-Simms submitted that it is to be borne in mind that these are patients that have routinely undergone dialysis treatment, some of whom have had a kidney transplant since that time. She submitted that the panel will be aware that there has been a significant passage of time and they could perhaps be forgiven for not

recollecting every detail.

Ms Fergus-Simms submitted that there is, sufficient cogent, strong and very reliable evidence upon which the panel can rely to support any determination made, and it is in the interests of justice to admit Patient 6's evidence.

Mr Finnegan opposed the application.

Mr Finnegan took the panel through to seven principles of *Thorneycroft* and made the following submissions:

1. *"Whether the statement is the sole and decisive evidence in support of the charges;*

There is no other evidence to directly support Patient 6 and accordingly it is the sole and decisive evidence in support of charge 3. He submitted that there has been reference made by Ms Fergus-Simms in relation to Witness 1's evidence covering these matters, however he submitted that Witness 1 made no reference in relation to Patient 6 in her witness statement or oral evidence.

2. *The nature and extent of the challenge to the contents of the statement;*

   Mr Finnegan submitted that it is his position that the witness statement of Patient 6 had been coerced by Witness 1 and it entirely consists of lies or that Patient 6 has mis-remembered events. He submitted that this is not a situation where the defence would simply be asking for clarification of different points, the intended cross-examination would go to the heart of the veracity of the contents of the documents.

3. *Whether there was any suggestion that the witness had reason to fabricate their allegation;*

   Mr Finnegan submitted that your position was that Patient 6 had reason to fabricate her evidence on the basis that Witness 1 had coerced her to make the complaint.

4. *The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;*

   Mr Finnegan submitted that charge 3 is not the most serious, however, it is nevertheless serious, concerning an allegation of tugging of a neckline and the implications that could potentially have on a patient and the covering of a face with a plastic sheet. He said it his understanding that Patient 6 made no complaint as to her ability to breathe.

5. *Whether there was a good reason for the non-attendance of the witness;*

6. *Whether the regulator had taken reasonable steps to secure the witness's attendance; and*

   Referring to the passing of Patient 6, Mr Finnegan submitted that there is no greater reason for a witness' non-attendance therefore points 5 and 6 need not be addressed.

7. *Whether the registrant did not have prior notice that the witness statement would be read."*

   Mr Finnegan submitted that the first he was made aware of this hearsay application was on the first day of this hearing based on Patient 6's ill-health at the time. He submitted that it is now over a week at this point, therefore there is little that turns on this issue.

Mr Finnegan submitted that evidence was heard yesterday (Day 6) from Patient 7 that there had been a discussion in Bay 3 at Clinic 2 between the patients and that patients had been speaking about the writing of complaints, and that a bundle of complaints had been given to Witness 1 at a particular time. He referred the panel to the part in Patient 6's witness statement where she states that she had attended Bay 3 at Clinic 2 which feeds into the questions he would have wished to ask Patient 6, as to what was being

discussed in Bay 3 and what may have been arranged between the patients at the time of her hand written complaint.

Mr Finnegan initially submitted that there is an inference that it appears as if the NMC witness statements have been formulated either entirely or to a significant extent by someone reading the handwritten complaint, typing the statement and then giving it to the particular witness to sign. He submitted that this also applies to Patient 6 and that is a question that he would have asked Patient 6 which is a significant factor to consider in this application. However, during the course of this application the NMC produced documentary evidence of how the witness statement was created. Mr Finnegan accepted that the witness statement was created as a result of discussions with the solicitors involved.

In terms of the relevance of Patient 6's evidence in relation to the other charges and the corroboration between the different witness statements and the live evidence that the panel has heard over the past few days, he submitted that there is an absence of strong or cogent, reliable evidence heard from other witnesses such that it could give the panel assurance that Patient 6's evidence can be admitted as hearsay evidence. He submitted that all the admission of Patient 6's evidence would do is to add more uncertain evidence into the mix of what is already a preponderance of unsure evidence. Mr Finnegan submitted that it is not a question of witnesses being forgiven for not remembering every point, rather witnesses were struggling to remember many specific points in the majority of their evidence.

Mr Finnegan submitted that In the circumstances, it would be unfair to allow this application as the prejudicial effect of this witness statement and corresponding handwritten complaint being admitted, outweighs its potential probative value. Therefore, in applying *Thorneycroft,* he invited the panel to refuse the application.

The panel accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included reference to the legal principles in the cases of *Thorneycroft, Ogbonna,* and *El Karout v NMC* [2019] EWHC

28 (Admin) and Rule 31 which provides that, so far as it is *'fair and relevant'*, the issues raised was it fair to admit hearsay evidence.

The panel therefore gave careful consideration to the submissions made and to relevant case law. It also had regard to Rule 31(1) which states:

> *'31(1) Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in the appropriate Court in that part of the United Kingdom in which the hearing takes place).'*

The panel having retired to make its decision was then provided with further documents that confirmed the veracity of Patient 6's written statement and how it came to be written. Before making its final decision on the application the panel reconvened the hearing and invited counsel to make further submissions in light of the recently received documents. The panel then adjourned again to make its final decision.

The panel had particular regard to the seven issues raised in the case of *Thorneycroft* and which had been referred to in Mr Finnegan's submissions.

The panel acknowledged that Patient 6's evidence was the sole and decisive evidence in support of the charge 3 and noted that the letter of complaint is not dated and therefore it cannot be said that it was a contemporaneous document or near contemporary document to the alleged events. The complaint letter makes a number of complaints but does not state when these events are said to have taken place and it is not said that each of these alleged events took place on the same day. The NMC acknowledged that issue by alleging that the events in charge 3 took place between May 2022 and 16 November 2022.

The panel recognised that there is no direct support from any other witness in relation to charge 3. The panel was of the view that in and of itself, the witness statement is largely consistent with her complaint letter and, to some extent, reflects a common theme from

other witnesses. The panel noted that there is no direct reference to corroborate Patient 6's evidence notably by Witness 1. The panel could not accept that the complaint letter could corroborate the later statement as both came from the same source.

The panel had particular regard to paragraph 45 of *Thorneycroft*: *'the panel must satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.'* In considering Patient 6's evidence, the panel was not satisfied that the evidence was demonstrably reliable and there was no other means of testing its reliability without some reference to it within the evidence of other witnesses.

All of the witnesses have been challenged in relation to their respective recollection of events and it has been put to them that most of the events, that they claim took place, never did. Patient 6 was due to attend, however circumstances have prevented this from happening. The panel recognised that in relation to the extent of the challenge, there would have been extensive cross-examination of Patient 6 on your behalf. The panel determined that in terms of testing the reliability of the evidence it would be unfair for Patient 6's witness statement and handwritten complaint to be left unchallenged in the circumstances.

In relation to the allegations being fabricated, the panel acknowledged that Mr Finnegan in his submission stated that your position was that Patient 6 was coerced by Witness 1 and that the coercion is linked to other witness evidence heard on Day 3 of this hearing. The panel determined that Mr Finnegan would have wished to put to Patient 6 that her evidence was fabricated and coerced and / or there was collusion between patients.

The panel determined that in terms of seriousness of the charge it is a small element of the overall charges in this case.

In relation to whether there was a good reason for Patient 6's non-attendance, the panel determined that, prior to Patient 6's passing, she had first intended and been prepared to attend this hearing as evidenced by the reasonable steps taken by the NMC to secure her attendance.

The panel determined that you did not have prior notice that the witness statement would be read into evidence and accepted that you were only told on the first day of this hearing, that Patient 6 would not be attending the hearing and would be the subject of a hearsay application. However, the panel noted that Mr Finnegan did not suggest that there had been a procedural ambush. He had been given enough time to consider the application and respond.

The panel considered fairness to both parties. It considered Ms Fergus-Simms' submission that Witness 1 provides support in her evidence in relation to the charge, however the panel determined that Witness 1 did not mention it in her written statement or in her oral evidence and does not cover this point at all. The panel determined that, because of the uncertainty of timing in Patient 6's undated handwritten complaint as well as the fact that there was no other external supportive evidence, the panel was not satisfied either that the evidence was demonstrably reliable, or alternatively that there was some means of testing its reliability.

The panel therefore determined that it would be unfair to admit Patient 6's witness statement, which included the complaint letter, as hearsay evidence and therefore decided to refuse the application.

Decision and reasons on application of no case to answer (Day 8)

The panel considered an application from Mr Finnegan, that there is no case to answer in respect of charge 3 in its entirety. This application was made under Rule 24(7) of the Rules.

Mr Finnegan submitted that, under the first limb of test in the case of *R v Galbraith* [1981] 2 All ER 1060, there is no evidence in respect of charge 3 in its entirety. In these circumstances, it was submitted that the charge should not be allowed to remain before the panel.

Ms Fergus-Simms did not oppose the application and submitted that the NMC offers no evidence in relation to charge 3.

The panel accepted the advice of the legal assessor, which included reference to the case of *Galbraith*.

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

The panel was of the view that, taking account of all the evidence before it, as well as its earlier decision not to allow the evidence of Patient 6 as hearsay evidence, there was no evidence upon which it could properly find charge 3 proved.

The panel accepted the application that there is no case to answer in respect charge 3 in its entirety and decided to allow the application.

Background

The NMC received a referral on 24 February 2023 from the Employee Relations Advisor at Fresenius Medical Care Renal Services (UK) Ltd (the Company), raising concerns alleging your lack of competence. You were employed by the Company as a staff nurse working at the Clatterbridge Dialysis Unit (Clinic 1), one of their dialysis clinics, from 27 October 2020 until 5 May 2022, having previously been employed in the same capacity by the Company at a clinic in Wandsworth since 2019.

In May 2022, ownership of Clinic 1 was transferred to the National Health Service (NHS) and you chose not to work for the NHS. You therefore applied for an internal transfer to Clinic 2 and successfully transferred over in May 2022. You joined Clinic 2 as a staff nurse on a supernumerary basis. An action plan, intended to improve your practice and in place at Clinic 1 was also transferred across and it covered the same objectives set out in Clinic 2’s induction plan. It was decided that you would be treated as a new starter and managed as a supernumerary staff member and placed on a Supernumerary Phasing Plan.

You underwent the induction process at Clinic 2. As part of this induction process, you met with Witness 3, the Clinic Manager, on a weekly basis, to undergo weekly progress reviews. Witness 3 would conduct the reviews based on her own direct experience of working with you and observing your practice and also based on information other members of staff shared with her. At the three-week review, Witness 3 noted the concerns/areas for improvement within your practice.

By the end of your 8-week induction process, Witness 5, Area Head Nurse of Operations, held a meeting with you where it was decided that you would undergo an informal performance improvement plan (PIP) for four weeks. Witness 1, Deputy Clinic Manager, observed your practice during this four-week informal PIP and held weekly PIP review meetings. Witness 1 has set out evidence detailing your lack of competence in your role.

Witness 1 informed you that you had not met the objectives in your informal Performance Improvement Plans (PIP). Following this, in November 2022, Witness 4, Senior Governance Manager held a capability hearing with you. It was decided that you would be placed on a formal capability plan for four weeks.

In November 2022, the Company received complaints from several patients about your practice. Following these complaints, Witness 6, Area Head of Operations, held a disciplinary meeting with you on 16 December 2022. It was found that you had failed to meet the objectives set in the informal and formal PIPs and youbwere dismissed by the Company on 22 December 2022 with immediate effect.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Finnegan that you made admissions to charges 4 and 5a(iv).

The panel therefore finds charges 4 and 5a(iv) proved by way of your admissions.

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

Fergus-Simms on behalf of the NMC and those made by Mr Finnegan 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 oral evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Deputy Clinic Manager at Clinic 2, at the material time
- Witness 2: Area Head of Operations (1) at the Company at the material time
- Witness 3: Clinic Manager at Clinic 1, at the material time
- Witness 4: Senior Governance Manager at the Company, at the material time
- Witness 5: Area Head of Operations (2) at the Company, at the material time
- Witness 6: Area Head of Operations (3) at the Company, at the material time
- Patient 4: Patient at Clinic 2, at the material time
- Patient 2: Patient at Clinic 2, at the material time
- Patient 7: Patient at Clinic 2, at the material time

The panel also heard evidence from you under oath.

The panel agreed that the parts of your evidence relating to [PRIVATE] be held in private under Rule 19 of the Rules.

The panel accepted the advice of the legal assessor which included reference to the cases of *Hindle v NMC* [2025] EWHC 373 (Admin) and *Dutta v GMC* [2020] EWHC 1974 (Admin).

Before making any findings on the facts, the panel addressed the following three aspects arising from this case.

A number of issues were raised on your behalf which would comment on the charges. These related to training, an allegation that patients were coerced into providing written complaints to the Company and it was submitted that the NMC witness statements were obtained in an unorthodox manner.

Awareness of the policy documents

You claimed that you were provided insufficient training and induction and the panel had regard to your evidence that you had not been provided sufficient time to read the policies. The panel considered the oral evidence and documentary witness evidence provided by both Ms Fergus-Simms and Mr Finnegan. In its consideration of the evidence before it, the panel noted that you had worked for the Company for three years since 2019 until 2022, in three different locations, (first at Wandsworth, then Clinic 1 and finally at Clinic 2) and were required to have read and enacted its policies related to your clinical practice as a nurse during the time you worked for the Company, particularly in relation to medication, health and safety, waste management and infection control. The panel noted that you had signed the Risk Assessment and Training Records which relate to the Company's policies and were offered time to familiarise yourself with them.

The panel determined that whilst you may not have read every single company policy there would have been a professional expectation for you to have read and been familiar with the ones connected to your clinical practice, such as medication, health and safety, waste management and infection control. The panel was of the view there is a duty as Registered Nurse to do so. In any event, there is no suggestion that there was a problem with your practice whilst you worked at the Wandsworth unit.

The panel noted that in response to its questions, when asked about your awareness of these policy documents, you told the panel that you were aware of these documents but were not familiar with the details. It also saw evidence that you were offered time to update yourself with them.

The panel had sight of the Company's NephroCare Standard Good Dialysis Care and NephroCare Standard Hygiene and Infection Control policies. The panel was of the view that they were not particularly lengthy documents and it was not unreasonable to expect for you to have read them and been familiar with them as they relate to your position as a nurse during the three years you worked for the Company. The panel bore this in mind in considering whether there had been any breaches of your duties in some of the charges.

Coercion

It was put to a number of witnesses that they had been *'coerced'* into making a complaint about your practice. The panel was not certain you understood the plain meaning of the word which involves the suggestion that these patients were forced against their will to complain about you. The panel determined that each of these witnesses provided their written complaints of their own free will and did so with a desire to draw their genuine concerns to the attention of the Company.

The panel was of the view that it was not unreasonable for a service user of any organisation to ask how to raise a complaint, receive information on how to complain and if having raised a complaint orally, be asked to put that complaint in writing. The panel was of the view that Witness 1, a senior nurse, would be following routine practice

in this regard.

The panel took no negative or positive inference from the fact that certain complaints were not made directly to you, rather they were made via the more appropriate and usual route.

Provenance of the witness statements

The panel had careful regard to the provenance of the witness statements obtained in relation to the evidence. The panel applied evidential weight to the contemporaneous documents available above that of the oral evidence it heard. The panel was of the view that Mr Finnegan's assertion that a number of the witness statements were obtained improperly was significantly mitigated by the fact that all of the patients, whose evidence the panel relied upon, had made contemporaneous complaints and had then undergone extensive cross-examination by Mr Finnegan. The panel was therefore satisfied with the veracity of the witness statements in evidence in this hearing and their production did not amount to an abuse of process. It could give the appropriate weight to each witness's evidence in the usual manner.

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

Charge 1a)

That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a dialysis nurse in that you:

1) Between 29 November 2021 and 1 November 2022 while subject to an action plan and/or informal capability process/informal performance improvement programme failed to meet the following objectives:

    a) Delivery of Patient Care.

This charge is found proved.

In reaching this decision, the panel took account of all of the relevant evidence. This included: the evidence of Witness 1 and Witness 3; Witness 1's Informal PIP weekly review meeting notes dated 2 August 2022; the Minutes of Disciplinary Hearing dated 16 December 2022 (at which events which occurred during the specified period were examined); weekly review for Performance Improvement Plan which included the objective *'Delivery of Patient Care'*; the Action Plan set on 25 November 2021 and your Clinical Practice Skills Assessment Record dated 25 November 2021. The panel noted that these documents included what the expectations and objectives were for your clinical practice.

The panel factored in the fact that your performance was being monitored and recorded by experienced nurses. The panel noted that there was a general theme of patient complaints continuing dating back to July 2021 at Clinic 1. The panel first had regard to the Clinical Skills Assessment record completed by Ms 1 and Witness 3 which noted on 25 May 2022 that you needed supervising with Central Venous Catheter (CVC) lines and that you were not on target with your supernumerary phasing.

The weekly review for Performance Improvement Plan dated 21 September 2022 completed by Witness 3, included**:**

> *'PW re infused the machine before she had connected the lines to the patient so machine alarmed high venous pressure. Once again I assisted her by talking through how to resolve it & she said that this hasn't happened before but I explained that she had jumped to the next stage on the machine before carrying out the disconnection to the patient with the lines.*
> *With CVC lines PW not using positive pressure when clamping CVC lines this discussed.*
>
> *When PW inserted needles to observed her throw the lines to move them out of the way, I observed that there was no regard to patient*

consideration and feeling, and the lines when clamped where torte not enough slack and without making to much of it and did discuss with PW and said can we did it like this just to ensure slack and room for patient movement.

Very little assessment witnessed with COVID 19 questions for patients.'

You accepted in oral evidence that patients were not happy with your care and that your problems started at Clinic 1 not at Clinic 2. The panel noted that this predates Witness 1's involvement with you as your preceptor at Clinic 2.

The panel was aware that for there to be a finding of failure you had to have been under a duty and for there to have been a breach of that duty. The panel had regard to the NephroCare Standard Good Dialysis Care Policy and the Clinical Skills Assessment Record which indicates that you were not '*on target'*.

In the Informal PIP weekly review meeting notes dated 2 August 2022, Witness 1 sets out your failings under 'Delivery of Patient Care':

'1.Not enough nor completed her assessment before connection of her patients .
2. With Cvcathetr patients Penny needs to be reminded that she needs to position her patients in semi
3. Blood pressure she always taking over the patients sleeves ,needs to remind ,prompt her to wait ,and tell the patients needs to sat upright before taking pre and post dialysis blood pressure .
4. Always needs to remind her when to check mid-observations and safety check whilst patient on their treatment , a on her documentation but missing to do other jobs on specific time.'

In the weekly review for Performance Improvement Plan dated 21 September 2022, Witness 3 highlighted various failings, including:

'*Today I observed PW whilst OR did MDT.*
I asked PW prior to disconnection to ensure each of her patients had all the correct equipment set out to enable her to be prepared for each patient with at least 2 out 4 patients we had to get further equipment out of the trolley.'
...

'*Very little assessment witnessed with COVID 19 questions for patients'.*

The panel took account that in her oral evidence Witness 3 told the panel that she had witnessed these incidents.

The panel was of the view that similar aspects of this charge were repeated by different people consistently over an extended period of time. The panel did not accept that three registered nurses had conspired to fabricate their respective evidence. You put forward no reason why any nurse other than Witness 1 would have fabricated an account.

The panel heard evidence that not everyone at Clinic 2 was aware of your previous experience and staff there were not briefed on it by management. The panel noted that there were a number of highly qualified nurses who provided mentorship to you over an extended period of time who independently reached their own perspective on your practice. There was no evidence before the panel of any conspiracy. At Clinic 2 it was clear to the panel that you were given an induction programme containing a number of objectives and there was nothing in it that a nurse of 30 years' experience with your qualifications would not have been able to achieve.

In your evidence you relied upon the assertion that there was a conspiracy among the witnesses against you, yet evidentially it was two independently run clinics with the only point in common interest was from Witness 2 who attended a meeting on day one to hand over the Action Plan.
The panel gave considerable weight to the contemporaneous documents and heard consistent oral evidence from Witness 1 and Witness 3 which was extensively cross-examined. The panel found them to be credible, reliable and consistent witnesses and it preferred their account to yours.

The panel therefore determined that while subject to an action plan and/or informal capability process/informal performance improvement programme you failed to meet the required objectives. The panel therefore found this charge proved.

Charge 1b)

b) Hand Hygiene and infection control.

This charge is found proved.

In reaching this decision, the panel took account of all the relevant evidence, which included the witness statements and oral evidence of Witness 1 and Witness 3. It had sight of the 'Clinical Practice Skills Assessment Record for Staff Nurse and Dialysis Assistant' started on 23 May 2022 and noted under 'Infection Prevention & Control' that none of the competencies on dates 4 July 2022 and 18 July 2022 were attained.

The panel took account of Witness 5's evidence that on 21 July 2022 she chaired a performance review meeting with you following concerns raised about your practice and it was decided during this meeting that you would be managed under a four-week informal performance improvement plan with set objectives. The panel noted that there were concerns at the Informal PIP weekly review meeting dated 22 September 2022, where it was noted that there were ten areas of practice under the hand hygiene and infection control objective which were not attained to meet with that objective.

The panel had sight of the NephroCare Standard Hygiene and Infection Control Policy in which includes a description of the *'five moments of hygiene'.* Witness 1's in her witness statement included that this was provided in your training pack to read as part of your induction. Witness 1 further states:

> *'... These hand washing and hand rubbing techniques*
> *are displayed as posters above all sinks, so it was clearly visible for Ms Wright to see.'*

...

'Ms Wright would also drop things, such as gauzes stained with blood and pick them up with the same gloves on and go to use the same gloves when touching the patient's access point. I would often have to stop Ms Wright from doing this. This is not acceptable practice as this can give rise to a risk of infection to the patient.'

...

'I also noticed that Ms Wright would not always change her gloves after cleaning the machine' para 34 doesn't change gloves after cleaning machines. May 22 you would hold the patients arm and needle etc

...

'Ms Wright would then try to hold a patient's arm and touch the needle puncture site with the same gloves. This is not in line with the Preparation, Use and Disposal of ClearSurf policy as this rise to a risk of infection.'

The panel took account of Witness 3's witness statement, which includes:

'Ms Wright had very poor hand hygiene and would often move from one patient to the next without cleaning her hands.'

Your evidence was that you always followed the five moments of hand hygiene and followed good infection control and that you have good aseptic technique. You said that you had knowledge of the procedures but not knowledge of all of the detail contained in the policies.

Given the considerable contemporaneous evidence supporting this charge and the consistency of the oral evidence of the witnesses, the panel finds this charge proved.

Charge 1c)

c) Waste segregation.

This charge is found proved.

In reaching this decision, the panel took account of the witness statements and oral evidence of Witness 1 and Witness 3. The panel had sight of the waste separation stipulations contained in the Company's policies.

Witness 3 in your week 3 progress review report dated 9 June 2022 stated that when questioned about waste management policy:

> *'I asked question[s] to test understanding, but Penny still was hesitant with responses. '*

Witness 3 stated in her witness statement:

> *'On 9 June 2022, I met with Ms Wright for her Week 3 progress review. During this meeting I went through Ms Wright's action plan with her and had particular discussions with Ms Wright about observations noted by myself, Nicola and other staff that had worked with her, who mentioned concerns to me, in respect of;*
>
> *[...]*
> *'ix. waste management and using the correct waste bins for waste, sharps in sharps bins, clinical waste in yellow bins, recycling in clear bags and general waste black bags'.*

The panel considered it important that Witness 3, in relation to the statement confirm that your behaviours had been personally witnessed by her, Ms 1 and others.

The panel had sight of the Clinical Practice Skills Assessment Record for 13 June 2022 which you and Ms 1 signed, and it included the comment *'Reminding discarding of*

syringe and plastics in correct place'. Witness 3 further stated that she had witnessed this practice herself. Her witness statement went on:

> *'I observed Ms Wright incorrectly placing clinical waste at the bottom of her trolley which was meant for recyclable waste and not using the yellow bag provided in the disconnection pack. I also observed waste blowing off her trolley and onto the floor causing a slip and trip hazard'.*

Witness 1's witness statement includes:

> *'Ms Wright would place gloves and a blood-stained paper towel into the dry mixed recycling bin. Ms Wright would also place a face mask used by a Covid-19 positive patient into the recycling bin. These items should have been placed in the clinical waste bin'.*
> *...*
> *Ms Wright would also not place used syringes into the sharps bin...Again, all of these actions were in contravention of the Nephrocare Policy, and Waste Separation in FME Dialysis Policy'.*
> *...*
>
> *'I explained the importance of proper waste segregation to Ms Wright many times. Above the bins is a poster explaining what the items should be disposed of in which bin. Ms Wright had training on this.'*

You said in oral evidence that you did segregate the waste and put it in the relevant bins. You said you did not know why either Witness 1 or Witness 3 would say that you did not. You later conceded that it may have happened on one occasion at least.

The panel relied on the contemporaneous evidence of at least three individuals who witnessed this type of behaviour from you and therefore could not accept your account. The panel therefore finds this charge is found proved.

Charge 1d)

d) Prioritising workload

The panel finds this charge proved.

In reaching this decision, the panel took into account all the relevant evidence.

In the Informal PIP weekly review meeting notes dated 2 August 2022, Witness 1 noted:

> *'Continue to use computer and continue to documents and not checking the mid - observations of her patients on the right time reminded ,prompt and instructed to do so. Late checking the mid observation, she needs to do medication on that time ended up of doing on my own (29-07-2022) Asking to go to break ,but always refusing her preceptors even though her preceptors explain why she needs to have break on that time for better running of the clinics and for time management of her bay.'*

Witness 1 repeated the same in her oral evidence and in cross-examination.
The panel took account of the Weekly review for PIP dated 21 September 2022.
Witness 3 states:

> *'PW had acknowledge that 2 of her patients would come off together. I said that I would take 1 patient off for her but for her to prioritise her work load with the other 3 patients. 2 out of the 3 patient there was an issue which delayed moving on the next patient. Missing equipment PW said can you get me this because she hadn't got enough equipment when aseptic. When not aseptic went for it herself. PW was working with another nurse due to being in a bay of 6 beds at lunch time she asked me who she was putting on I asked PW to talk to SA and decide a plan between them due to her working opposite her. So PW not forward planning, communicating with her colleagues and using initiative when managing her patients and workload. Duplicating work writing on a piece of paper rather*

than dialysis summary chart. PW when connecting and disconnecting a patient doesn't have a clear logical sequence of doing this it is very mismatched in her approach.'

The panel took account of the notes of Witness 1 in the Informal PIP weekly review meeting notes dated 22 September 2022.

'When she's asked to go on break, she always ignored and not following instruction even though explaining to her the reason as it's important for her time management to deliver care on her bay. Due of this she always struggles to do things for her patients (like dressing change, preparing medication. This is causing patient to wait for their reinfusion and patient going late.
Example: MWF pm patient in bay 4) said to her your patient is your priority not documentation when Penny said she haven't finished her documentation.'

Witness 1's witness statement included:

'Ms Wright would be asked to take her break at a certain time , in order to try and ensure the dialysis timings for patients in her bay would run smoothly. Each nurse has their own designated duties and if Ms Wright was late for her break, it would have a knock-on effect on everyone else's breaks and their assigned duties...'

...

'Ms Wright would always ignore our requests for her to take her break and she would take her break when she wanted to. This contributed to Ms Wright's poor time management and delivery of care to her patients, as she would run late. It also had a knock-on effect on the running of other members of staff's duties. MS Wright would not work co-operatively with us'.

Your evidence was that you were distracted on many occasions by Witness 1 and that no sooner were you doing one task you were asked to do another. You gave an

example in response to questions that you were being asked to set up the machines in one bay and then immediately after was asked to set up the machines in another bay by Witness 1. When questioned in your oral evidence, however, you confirmed that these tasks were sequential and you were not taken to attend to task 2.

The panel noted that in your oral evidence, you did accept that you would refuse to take a break if it compromised your patients and said your patients would come first, not when Witness 1 demanded you take a break. The panel reminded itself that you were supernumerary and it was therefore axiomatic that you would take your break at the same time as your supervisor. Moreover, the supervisor would be very well aware of the status of any patient affected at that time. The panel accepted Witness 1's concern that your refusal to take breaks interfered with the break schedule of other nurses.

The panel determined that it had been provided with three contemporaneous and credible sources of evidence, two of them from nurses whose account corroborated each other and was consistent with the contemporaneous evidence. The panel relied on this evidence and gave it considerable weight. The panel was of the view that it is in the nature of the role of a registered nurse that there is a general duty to manage competing tasks and their workload. The panel determined that distractions are a regular part of nursing and that any registered nurse normally would be asked to do things and to change tasks at short notice which is not in itself unusual.

The panel determined that you did fail to prioritise your workload and therefore finds this charge proved.

Charge 1e

e) Providing patient dialysis in accordance with individual dialysis prescription.

This charge is found proved.

In reaching this decision, the panel took into account all the relevant evidence.

The panel had sight of the NephroCare Standard Good Dialysis Care Policy, Clinical Practice Skills Assessment Record for Staff Nurse and Dialysis Assistant and noted that there were two elements of those standards and competencies that you did not achieve.

The panel had sight of the Datix Report and Medication chart of Patient 14 and noted that you did not administer the prescribed 20mgs of Enoxaparin to Patient 14 at the start of dialysis. You were observed by Witness 3 and made an apology to the patient. The panel noted that this was recorded as a '*near miss'.*

The panel noted Informal PIP weekly review meeting notes dated 22 September 2022 that concerns were being raised about you not following policy and not checking blood glucose monitoring for diabetic patients, or following patients' prescriptions**.**

In the File Note dated 21 September 2022 – Weekly review for PIP both Witness 3 and Ms 1 both identified your failure to check prescriptions. Witness 3's witness statement includes:

> *'On 3 June 2022 and during Ms Wright's Week 2 review in terms of the Supernumerary phasing plan, [Ms 1] confirmed that Ms Wright was not on target in terms of the supernumerary phasing and that she needed to familiarise herself with the dialysis machines, to read through the instructions on the dialysis machine and to ensure that she compared the patient card of the patient receiving treatment with the prescription of that patient. [Ms 1] formulated a further action plan and Ms Wright was to ensure that she remembered that when reinfusing the machine to be ready and to not turn the machine on until she was ready'*
>
> **...**
>
> *'After downloading her patient's identification card from the Therapy Monitor software system (TMon), which provides details about the patients and their treatment, I witnessed Ms Wright failing to check her patient's identification card*

against the patient's prescription. The patient identification cards contain information specific to that patient. We have had instances where some patients have a similar name so it is vitally important to check that we are administering the correct treatment and prescription to the correct patient. Failing to check this information correctly could result in a patient receiving the incorrect dialysis treatment or prescription and this could lead to catastrophic consequences for the patient involved.'

Witness 1's witness statement included:

'Ms Wright was not reading the patient's individual dialysis prescription. It is a very detailed prescription, which outlines their kidney size, how many hours is required, the size of needle required and what the blood flow rate is and the needle access site (either fistula or catheter). In line with the NephroCare Policy, staff should always be working from the prescription. Ms Wright would ask the patient, "where can I needle?", instead of checking and following the prescription and by following the VascularAccessforHaemodialysisClinical Practice Guide.'

...

'Ms Wright would also ask the patient if they checked their blood pressure and temperature. This is completely inappropriate, and the nurse should be taking these readings themselves to ensure they are correct. Ms Wright would sometimes get the wrong needle size too as she was not checking the prescription.'

Witness 1 also stated the same in oral evidence that you would get the needle size wrong as you were not checking the prescription.

Your evidence was that you did not receive sufficient training for working at Clinic 2. You denied that you did not check the prescription and said that you always checked the prescriptions and that sometimes the Health Care Assistants (HCA's) would set up the preparation tables with the needles that reflected the prescription and you would always check them later. Further, you maintained that you were constantly distracted by

Witness 1. You did admit to not administering the Enoxaparin but said this was due to distractions.

The panel considered your oral evidence regarding a contemporaneous patient record when under cross-examination you maintained that the Ultra Filtration Goal (UFgoal) was 1300 litres when it was obviously incorrect. You persisted with this view saying you could take 1300L even when it was put to you that such a figure was impossible you did not resile from your view. Only the following day in your cross-examination did you finally appear to accept that you could never have a UFgoal of 1300 litres. The panel was concerned that during much of your evidence you did not appear to appreciate the difference between litres and millilitres.

The panel preferred the evidence of Witness 1 and Witness 3, whose accounts were supported by contemporaneous documentation, to your assertions.

The panel determined that you did fail in providing patient dialysis in accordance with individual dialysis prescription and therefore finds this charge proved.

Charge 1f)

f) Providing individual patient care.

This charge is found proved.

In reaching this decision the panel took account of all the relevant evidence.

The panel had regard to Witness 2's witness statement and documentation which included 1:1 Meeting Notes from 6 December 2021 to 2 January 2022, signed by Ms 3 and Ms 4.
Witness 2 notes that you failed to note the correct filtration rate on 8 December 2021 as your pre-assessment of the patient was inadequate.

The panel had regard to the NephroCare Standard Good Dialysis Care Policy, which directs the nurse *'to perform accurate nursing assessment noting any changes in patient*

general status.', to *'evaluate the patient's general condition'* and then record any *'variants'* of treatment. The panel determined that this was direction to personalise individual patient care at every treatment.

Witness 3's witness statement includes:

> *'We would do our best to personalise the patients' care and each patient's treatment is unique to that patient. A patient's treatment may need to be varied as their fluid may be different to what it may have been during their last dialysis treatment and their treatment will therefore need to be varied accordingly. Ms Wright did not demonstrate an understanding of this and would often fail to undertake assessments on patients to determine if their treatment for that day needed to be varied.'*
>
> Further, Witness 3 in her witness statement recalled:
>
> *'In one instance I had asked Ms Wright what fluid had previously been removed from a patient and at first, she looked at me blankly, before eventually looking at the patient's dialysis summary chart.'.*

The panel considered this to be evidence that you were not aware of that patient's individual treatment.

Witness 1 in her witness statement included:

> *'Ms Wright would not listen to the patient's wishes. For example, Patient 1 said to Ms Wright that she could not tolerate all of her fluids being taken off, and asked Ms Wright to take off less fluid on that day... Patient 1 wanted less fluid taking off, but Ms Wright did not do this. Patient 1 was not happy about this.'*

The panel had sight of Patient 2's Complaint to the Company which although dated 14 November 2022, he evidently refers to your practice he has experienced in the

preceding weeks or months and from this the panel inferred that it fell within the period specified in the charge:

> *'There is also a real problem with Penny leaving notes on my machine when setting my timer. She did not leave any notes regarding my fluid removal and this has been pointed out nearly every time she is attending to my needs...additionally she doesn't appear to be able to remember what she is being told as when she asked what I started on with my pump speed I told her 350 – then when she asked me shortly after what pump speed it was she suggested it was 300, so I had to correct her. '*

The panel determined that Patient 2's evidence corroborated Witness 1's evidence in that your practice was negatively affected by you not listening to patients and / or ignoring them. The panel found that this eroded the confidence of patients in your practice. As such, the panel had regard to the Fresenius Week 1 - 8 Assessment Record, included as part of Witness 3's evidence and signed by you, which states:

> *'Patients feel unsafe with Penny and are refusing for Penny to care for them'.*

You said when asked that you would have acted on their wishes if the patients had told you of a specific request and put the timer on if the patient requested it. You asserted that you had been constantly distracted by Witness 1 and when asked in cross-examination whether you had been distracted by Witness 3, you merely said that Witness 3 was not there for a large period of time. The panel considered that there had been a degree of deflection in your response to the question.

The panel determined that Witness 1 and Witness 3 provided consistent and credible evidence, supported by contemporaneous documentation and the local complaint by Patient 2. It preferred their evidence to your denials.

The panel finds this charge proved.

Charge 1g)

g) Treating colleagues with respect.

This charge is found proved.

In reaching this decision the panel took account of all the relevant evidence.

The panel determined that there is a general duty on a nurse and part of the 'The Code' Professional standards of practice and behaviour for nurses, midwives and nursing associates 2015 (The Code) to act with professionalism and trust.

The panel bore in mind that Witness 1 and Witness 3 were two colleagues who were supervising you during your time at Clinic 1 and Clinic 2 and that Witness 3 was the more senior of the two colleagues. It also took account of the fact that Witness 3 was supervising you at the start of your time at Clinic 2.

The panel was of the view that Witness 1 and Witness 3's evidence was broadly consistent with each other. Although Witness 1's evidence was that you were abrupt and disrespectful most of the time, Witness 3 accepted that you were generally respectful but could sometimes be abrupt. The panel noted that there is some evidence from a number of patients to corroborate the evidence of Witness 1 that you were disrespectful. The panel found no material inconsistencies between Witness 1 and Witness 3 in this regard. Although the complaints submitted by patients are ostensibly outside the dates specified in the charge, the panel found that from the nature of the communications they were referring to observations of your practice over a period of time.

The panel had regard to the contemporaneous evidence before it. It considered Informal PIP weekly review meeting notes dated 2 August 2022 when Witness 1 noted:

'Still snapping colleague at times when they trying to tell something for her, so if

they asking her to help for daily job, or answering buzzer.'

...

'When I tried to tell her the right thing, or to correct her, Penny didn't respect what I had to say, she then went to another patient because of her anger she failed to observed her surrounding which lead to the acid fell down to the floor...Ended up of me who's cleaning it and Penny just watching it, and she's not apologising at all to the patient or to myself. It shows that she not only lack of self-respect but lack of respect to the most important people our patient'.

In the Informal PIP weekly review meeting notes dated 6 September 2022:

Again, when I'm trying to correct her, Penny didn't respect what I had to say. She will become snappy feels angry...'

Patient 7's witness statement included:

'I remember one instance in which [Witness 1] *was directing Ms Wright whilst she was preparing me for dialysis. At one point,* [Witness 1] *had to briefly leave the bay and whilst she was gone, Ms Wright leaned in close to me and said, "punch me now, this is doing my head in, go on just punch me now", or words to this effect. Ms Wright said she was sick of the staff treating her like this. I was completely taken aback by Ms Wright saying this to me, and saying it so close to my face. I felt that it was completely inappropriate and I felt very uncomfortable.'*

...

'Ms Wright could be abrupt with the other nurses, especially a nurse called [Witness 1]. *Ms Wright would say things to the effect of, "why are you watching me?" and, "/ know what I'm doing, I've been doing this for 40 years". Ms Wright did not seem to like other nurses instructing her or telling her what to do, and she could be passive aggressive. Ms Wright would proceed to slam things down on the table and shut cupboard doors loudly and was quite heavy handed*

when doing so. Ms Wright would act in this way in front of us patients, and it would make me feel uncomfortable and on edge'.

Your evidence was that the *"punch me now..."* comment was a complete lie and the patient is not telling the truth. You said that you never banged machines and cupboards. With regard to respect, you said that colleagues did not treat you with respect and at various points suggested that colleagues themselves had breached the Code.

The panel was of the view that there were no material inconsistencies between Witness 1 and Witness 3's evidence who were senior colleagues observing you, and their evidence is supported by a number of patients who had also observed you, that you could be abrupt or rude.

The panel finds this proved.

Charge 1h)

h) Medication management.

The charge is found proved.

In reaching this decision the panel took account of all the relevant evidence.

The panel had regard to the Medication Management Policy and Witness 3's evidence.

'The File Note dated 9 June 2022 – Week 3 Progress Review' showed evidence of you not checking prescriptions at the time of administering medication and that you *'missed sodium and lidocaine on a prescription for a patient'.*

The Datix Report and Medication chart of Patient 14 showed evidence of missed medication administration:

'Penny has sings [sic] and acknowledged on Euclid the administration of clexane however at the end of dialysis session, clexane dose still on patients table and dose not given. Penny informed and apologised when she realised that she had missed it.'

The 'Informal PIP weekly review meeting notes' dated 2 August 2022 indicates that concerns were raised regarding you forgetting medication and to ask the patient's name and date of birth against the medication chart and that signatures on medication charts were missing and that you signed for medications when there was no doctor's signature on the relevant document.

Witness 1's witness statement includes:

'Ms Wright would not accurately record on patients' medication administration charts. I exhibit a sample of medication charts completed by Ms Wright ...For example, the first page of [Sample of Medication Charts] is a medication chart for Line Lock medication. Ms Wright recorded that she administered 10ml of Line Lock medication to the patient. This patient did not require Line Lock as their access site was AVF and Line Lock is only used for CVC patients. Ms Wright used the incorrect medication chart, she should have used the chart for Sodium Chloride (saline), not Line Lock. I know this because Line Lock is not administered beyond 1.8mls, and Ms Wright recorded that she administered 10mls. [Sample of Medication Charts] shows that Ms Wright would not always sign her name or the date and time the medication was given. It is important to note that the consultant/prescriber always completes the top section of the medication chart, and the nurses complete the chart beneath, which shows the date, time and dose administered.'

Witness 1 in her witness statement confirmed that you were provided with the Medication Management Policy.

Witness 3's witness statement includes:

'...Ms Wright would administer the medications but would not sign for them and this would result in us not having a record if the medications were administered...'.

...

'We had to constantly watch her to ensure that she was doing what she was required to do, which put pressure on staff in addition to their own workloads.'

...

'Ms Wright had completed the patient card for the morning. I noted that she had signed for Enoxaparin, which is an anticoagulant, however she had not signed for saline and lidocaine, a local anaesthetic, for the patient. I discussed this with Ms Wright and she advised me that she had signed for these medications but the charts showed that she had not'

Witness 1's witness statement identified that you were not following the Control of Patient Supplied Product Policy in that when taking medication from the stock cupboard you were not checking this against existing stock. Further, when the clinic received patient medication you were not writing on the control of patient products form or counting the medication. These procedures ensure all patients have required medication available. You were shown and taught how to complete these procedures.

You said in oral evidence that control of patient supplied product was not completed appropriately as you have only done this two or three times so were not sure. Your response when cross-examined by Ms Fergus-Simms was that you were aware of the policies but not *"massively"* and you received no specific training for the medication management policy. You accepted that you may not have signed the prescription on 9 June 2022 but said that you were generally accurate. In oral evidence you admitted that the entry for the Linelock was recorded by you on the incorrect prescription chart.

The panel considered that you had been provided with the Medication Management Policy and your admission that the prescription had been written incorrectly. The panel determined that you failed to meet the medication management objectives set for you.

The panel relied on the contemporaneous evidence provided as being likely to being reliable, supported by consistent oral evidence and therefore preferred the evidence of Witness 1 and Witness 3 to your account. Accordingly the panel finds this charge proved.

Charge 1i)

i) Safety checks.

This charge is found proved.

In reaching this decision, the panel took into account all the relevant evidence.

The panel had regard to the Informal PIP weekly review meeting notes dated 2 August 2022 which recorded that you were not checking the bed brakes, earth cables or that the patients had their own nurse call buzzer. It then considered the review meeting notes of 26 August 2022 which recorded that you were still not checking: if the brake is on before patients arrival; earth cables on the machine and on bed before commencing the treatment and if the patient got their nurse call before leaving the bay. The same failures were identified in the PIP weekly review meeting notes for 6 September 2022.

The panel noted that these same three issues were raised as issues of concern in the Minutes of Disciplinary Hearing dated 16 December 2022 and Letter of Outcome of Disciplinary Hearing dated 22 December 2022.

The panel noted your evidence that you always did the safety checks and recognised the importance of doing so.

The panel was satisfied that there was sufficient contemporaneous evidence, supported by the oral evidence of Witness 1, which it preferred to you denial. Accordingly, the panel finds this charge proved.

Charge 2a and 2b)

2) Between May 2022 and 16 November 2022 in respect of Patient 7:
   a) On one or more occasion pulled/tugged their neck line.

   b) On one or more occasion did not refrain from pulling/tugging their neck line after being told by them that it caused discomfort/pain.

The panel considered Patient 7's witness statement, which includes:

> *'When Ms Wright would connect me to the machine, she would hold and tug at my lines whilst she was trying to set things up. This happened on multiple occasions. She would hold onto the lines and turn and reach over to the silver trolley, which contained the equipment she needed. The trolley had wheels on so I do not know why she would not wheel it closer to her. The pulling sensation made me feel really worried and it made me feel physically sick. When she did this, I would always tell her she was pulling on my lines, and she would dismissively respond, "you'll be alright" or, "It's fine". I would explain to her that no, it was painful, but she did not seem to show concern about this or make any attempt to change what she was doing.'*

The panel considered Patient 7 to be a credible and reliable witness. It determined that Patient 7 also gave oral evidence that was consistent with her local complaint and there would be no reason for her to fabricate her evidence. The panel was of the view that her evidence was not wholly dissimilar to that of evidence from other patients. The panel determined that there was no evidence of collusion and whilst she did discuss it with other patients there is no evidence that her evidence was fabricated. The panel rejected the assertion that being asked by Witness 1 to formalise her verbal complaint in writing was in any way akin to coercion.

The panel took account of Witness 2's witness statement, which included: *'...she was disorganised and could be a bit rough, and this caused the patients to feel on edge...'.* The panel was of the view that this accords with Patient 7's account.

The panel relied on the contemporaneous version of events provided by Patient 7 who also said in oral evidence that she had reported this to Witness 1 and had noticed that the trolley was three steps away, that you were all a bit disorganised and you pulled her neck line. The panel determined that this was indicative of a true account of events.

The panel noted that you sustained your position under extensive cross-examination that this did not happen and that the evidence of Patient 7 was fabricated.

The panel gave weight to the near contemporaneous account provided by Patient 7, which was supported in general terms by the evidence of Witness 2, and accordingly, preferred her evidence to yours.

The panel finds this charge proved.

Charge 2c)

c) On a date unknown inserted a swab into rather than around their neck line.

In reaching this decision the panel considered all the relevant evidence.

Witness 1 in her witness statement includes:

> '[Patient 7], *raised in her complaint that Ms Wright inserted a swab into her neckline. I think* [Patient 7] *was referring to Ms Wright completing an MRSA swab, that is completed once every month. When completing this swab, the nurse should not insert the swab into the exit site. The nurse should just swab the area around it. This is because inserting the swab could hurt the site, cause discomfort to the patient and there is a risk that the site could become contaminated with infection.'*

In Patient 7's handwritten letter of complaint dated 15 November 2022 she describes that she '*winced with pain and told Penny to stop...it made me feel sick*' .

Patient 7 describes what had happened in her witness statement:

> *'Before I am connected to the dialysis machine, my neck line area was cleaned with a swab every time...On more than one occasion (I cannot recall the specific dates), when Ms Wright was cleaning my neck line, she would insert the swab into the area. Ms Wright should not do this, the area around the hole should just be cleaned. I would always tell Ms Wright that she should not swab inside the neck line and I told her that it was painful and made me feel physically sick. Ms Wright would say, "It's okay it doesn't hurt", even though I told her that it did.'*

Your oral evidence was that it is physically impossible for this to have happened.

It is the panel's understanding that the meaning of *'inserted'* in this instance applies to any degree of insertion as opposed to going around the edges. The panel preferred Patient 7's contemporaneous evidence, supported by her consistent oral evidence and that she reported it to Witness 1 (as acknowledged by Witness 1) and preferred their account to yours.

The panel therefore finds this charge proved.

Charge 2d)

d) On an unknown date wrongly applied a gel dressing despite them advising you they were allergic to gel dressings.

This charge is found NOT proved.

In reaching this decision the panel considered all the relevant evidence.

The panel took account of Patient 7's oral evidence said that she *'may be allergic'* to gel dressing. The panel was aware that there is no supporting Datix report and finds no supporting evidence in relation to the specifics of this charge.

The panel noted Witness1 in her witness statement included that Patient 7 raised with you that she was allergic to the gel dressing, however the panel could find no supporting evidence to substantiate this charge and determined that the evidence was ambiguous. It was not clear whether Patient 7's allergic reaction was detected after the dressing was removed two days later.

The panel determined that the NMC has not discharged its burden of proof in this charge. The panel determined that this charge therefore has not been made out and accordingly finds it not proved.

Charge 5

5) Between 3 November 2022 and 16 November 2022 while subject to a formal capability process/formal performance improvement plan you:

   a) On 11 November 2022 in respect of Patient 2:
      i. Did not prepare the dialysis machine prior to them attending.
      ii. Delayed starting their dialysis treatment by over 50 minutes.
      iii. Required to be prompted to remove air/aspirate the syringe/needle containing saline solution.

In reaching this decision the panel took account of all the relevant evidence.

The panel considered Patient 2's local Complaint to the Company dated 14 November 2022 which included a chronology of timed entries to support his complaint of delayed dialysis treatment. Patient 2 had kept a log of events on his mobile phone at the material time. The panel gave weight to this as it was near contemporaneous and likely to be more reliable than memory alone. The panel determined that Patient 2 had no reason to fabricate his evidence. The panel find that Patient 2's evidence of your practice is broadly consistent with that of other patients at Clinic 2.

Patient 2's witness statement includes:

'On this day my dialysis session was delayed by approximately 55 minutes. Ms Wright was the nurse in my bay and when I arrived, she had not yet prepared the dialysis machines and this is normally always done. I usually arrive and I am connected to the dialysis machine straight away. Whenever Ms Wright was the nurse in my bay, I was always delayed approximately 30 minutes or more in getting connected to the machine. Sometimes I would be delayed up to one hour. It would usually take other nurses approximately 15 minutes to connect me to the machine. Ms Wright's delay started to become a pattern and it caused issues with my personal schedule, in terms of child care, as I was getting home late.'

The panel was of the view that a lack of preparedness was a factor in your practice and it was mentioned by Witness 3 in her witness statement:

'[Ms 1] *formulated a further action plan and Ms Wright was to ensure that she remembered that when reinfusing the machine to be ready and to not turn the machine on until she was ready'*
...

'[Ms 1] *and other staff that had worked with her, who mentioned concerns to me, in respect of;*
i. administration of a dialysis treatment and being more prepared before administering any treatment'.

The panel noted that you denied that there had been any delay but asserted that if there had been it would have been the result of distraction from Witness 1.

The panel considered that Patient 2's near contemporaneous account which had been logged on his mobile phone at the time, provided a reliable account upon which the panel could rely. It found it more likely than not that his treatment was delayed. It also noted that the failure to prepare the machine was recorded at the time by Patient 2 and preferred his evidence on this issues to your denial.

Regarding the aspiration of syringes the panel considered Patient 2's local complaint letter and the time entry at 12:55 in which he highlights:

'DANGER: Penny did not aspirate the saline solution lines correctly before attempting to place needles into me. Also; she did not aspirate the Saline solution syringes...It took me to repeatedly pointing out where the air bubbles were (3/4 times) and she seemed at this state to have an attitude over the matter'

The panel considered this to be a statement highlighting his significant concern at that moment for his treatment.

You said in evidence that it was bizarre for Patient 2 to be logging events on his phone and that he was coerced to do so and / or to make his complaint. However, the panel found no evidence to support your assertion.

Witness 1's Observation notes dated 11 November 2022, include:

'...she primed it but I noted that the two needles got lots of air on both needle got 1-2 mls of air, but then she ignored it and starting to clean [Patient 2's] *site, I stopped her and asked her to check the needle as I told her it's dangerous if she introduced the air to her patient, but she continue to do what she's doing, again I stopped her and asked her to prime her needle properly ...she is not very happy to follow what I'm advising her to do...'*

You denied that there was air in the needle other than perhaps a micro-bubble.
You said in oral evidence that syringes containing saline came pre-primed, however, when questioned by the panel you said that you drew it up in the needle. The panel found your evidence to be inconsistent. Others witnesses gave clearer credible evidence which the panel preferred. The panel determined that even if the needles were pre-filled you would still need to prime the needle and check for air.

The panel took account of Patient 2's local statement and oral evidence and noted the nature of his entry highlighting the danger and concern he had for his treatment and danger of getting air in the needle. Patient 2 and Witness 1 were both direct witnesses

to this incident and both made contemporaneous records of the incident, as well as giving consistent oral evidence. Accordingly, the panel preferred their account to your evidence in this regard. The panel determined that there is very clear corroborative evidence and contemporaneous documentation to support this charge. It therefore finds this charge proved.

Charge 5b(i) and 5b(ii)

b) On 11 November 2022 in respect of Patient 3:
   i. Did not wipe down their lines prior to connecting them to the dialysis machine.
   ii. Were unable to insert their needle to commence dialysis.

These charges are found NOT proved.

In reaching its decision the panel took account of all the relevant evidence.

The panel considered Patient 2's evidence was that he did not witness you wipe Patient 3's lines before or while administering Enoxaparin into his lines and that you had difficulty inserting Patient 3's needle. He stated, under cross-examination, that he did not see this happen when he was observing you but acknowledged that his attention was not on you at all times. When further questioned, he acknowledged that he may not have seen you perform the necessary procedures but later stated that he did not see this happen while he was observing you. When cross-examined he said that he may not have seen it.

The panel noted that Witness 1's Observation notes dated 11 November 2022 contained more general observations and did not refer to this specific incident. Her witness statement is clear that she is referring to another patient and not to Patient 3.

The panel finds that it is not proved that you did not wipe down Patient 3's lines prior to connecting them to the dialysis machine, nor that you were unable to insert their needle to commence dialysis.

Charge 5c)

c) On 11 November 2022 handled Patient 5's needle without wearing gloves.

This charge is found proved

In reaching this decision the panel took account of all the relevant evidence.

The panel considered the oral evidence, witness statements and local complaint letter from Patient 2.

In his local complaint letter, he states:

> *'13-20 - Penny appears to be struggling to get Patient 5's blood to flow from his fistula...Then when Patient 5 said he was getting pain from his fistula she did not wear any gloves to adjust his needles.'*

In Patient 2's witness statement he includes:

> *'I also noticed that when Ms Wright was handling another* [...] *another patient, needle, she was not wearing gloves.'*

Witness 1's witness statement includes:

> *'I had to stop Ms Wright and prompt her to disinfect her hands and change her gloves after she had picked something up off of the floor or cleaned the dialysis machine, as she went to connect a patient to the dialysis machine, wearing the same gloves. Ms Wright also did not disinfect her hands after cleaning the silver trolley.'*

Your evidence was that Patient 2 was coerced to give his statement but you asserted that in your practice you would always have worn gloves.

The panel was of the view that there is a common theme around this point from separate witnesses. The panel gave weight to Patient 2's contemporaneous evidence. It determined that Patient 2 was a credible witness who had produced an almost minute-by-minute report based on his observations of you at the time.

The panel preferred Patient 2's evidence of your practice to yours and it was corroborated to a great extent by Witness 1. The panel determined that this was a pattern of behaviour affecting your practice and therefore more likely than not to have happened. The panel therefore finds this charge proved.

Charge 5d(i) and Charge 5d(ii)

d) On 11 November 2022 and/or 15 November 2022 in respect of an unknown patient/s:
   i. Did not check the earth cable was connected properly to their dialysis machine/s.
   ii. Did not check bed brakes.

These charges are found proved.

In reaching this decision the panel took account of all the relevant evidence.

The panel considered in your oral evidence you were not able to give a clear understanding of the earth cables and their importance. The panel relied upon the Observation notes provided by Witness 1. The panel also noted that you were unable to recall the dates in question.

In the Observation notes dated 11 November 2022, Witness 1 noted that when it was your turn to do what was shown to you a few minutes prior, you had to be reminded as you had already forgotten what you had observed. A given example of this was that you forgot to check the earth cable and to check if the bed brake was on or not.

The Observation notes dated15 November 2022 includes:

‘still not checking the earth cables and brakes of the bed before commencing treatment’.

The panel gave weight to the contemporaneous Observation notes and consistent oral evidence from Witness 1 and preferred her evidence to yours. The panel therefore finds these charges proved.

Charge 5d(iii)

5d(iii) Did not compare their pre-dialysis weight and post dialysis weight.

This charge is found NOT proved.

Witness 1’s witness statement includes under ‘Safely connect four patients to a dialysis machine’:

‘...When it was Ms Wright's turn, she did not check the earth cable was connected properly to the dialysis machine, if the patient's bed brake was on, she did not compare the patient's pre-dialysis weight and last post dialysis weight and she did not assess if the patients had oedema, etc. Ms Wright did not complete the pre-safety checks or assess them for eovid-19 sign and symptoms. Ms Wright also missed completing the mid-observations of a patient.’

However it could find no supporting contemporaneous evidence to support this charge. The panel was of the view that the NMC has not discharged its burden of proof in this charge. The panel is not casting any doubt on Witness 1’s overall credibility, merely there is a lack of any contemporaneous documents against which to test its reliability on this sub-charge. The panel therefore decided therefore that in the absence of any contemporaneous evidence upon which it could rely. The panel therefore finds this charge not proved

Charge 5d(iv), 5d(v), 5d(vi), 5d(vii)

iv. Did not assess for oedema.
v. Did not check for shortness of breath.
vi. Did not complete the pre-safety checks.
vii. Did not assess them for Covid-19 signs and/or symptoms.

In reaching this decision the panel took account of all the relevant evidence.

The panel had regard to the contemporaneous Observation notes dated 11 and 15 November 2022. The notes from 11 November 2022 refers to pre-safety checks and includes comments that you were still not consistently asking patients for symptoms of Covid-19 before commencing their treatment. The notes from 15 November 2022 also state that you were not checking patient's lower extremities for oedema or if patients were experiencing shortness of breath. Additionally, it was recorded that you were:

> *'1, still not checking earth cables on machines and chairs of patient before commencing dialysis. 2. Still not checking breaks [sic] of the bed before commencing the treatment.'.*

The panel relied upon the contemporaneous evidence in the Observation notes and was satisfied that there was satisfactory cogent evidence before it with which to find these charges proved.

Charge 5e(i), 5e(ii) and 5e(iii)

e) On 11 November 2022 in respect of Patient 9:
   i. Required to be prompted to remove their clothing to check their blood pressure.
   ii. Failed to administer their Enoxaparin.
   iii. Required to be prompted to sign their medication chart.

These charges are found proved.

In reaching this decision the panel took account of all the relevant evidence.

Witness 1's witness statement included:

> *'I had to remind Ms Wright again to not check Patient 9's blood pressure over his clothes. I also had to remind Ms Wright to sign medication charts as she forgot to sign them.*
>
> *Ms Wright connected Patient 9 to the dialysis machine. The machine's alarm kept going off, so I reviewed it and noticed that the venous pressure was creeping up. This means that there was an indication that the blood was starting to clot. I then noted that the patient's Enoxaparin (anti-clotting) injection was on the table. I asked Ms Wright about this, and she said she forgot to administer it to the patient. ... I managed to prevent any issues from happening as I administered the Enoxaparin.'*

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Her witness statement is broadly supported by her Observation notes recorded on 11 November 2022.

Your evidence when cross-examined was that because of the many distractions Witness 1 placed on you when you were working with her, she '*threw you under the bus'* all the time. You said that if you had failed to administer Enoxaparin it would have been a medication error if that had occurred. In relation to having to be prompted to complete the medication chart you said that you do not recall Witness 1 saying that but she may have done. You said you always did a patient's blood pressure correctly.

The panel determined that, notwithstanding the absence of evidence from Patient 9, it was satisfied that there was cogent, reliable and contemporaneous evidence from Witness 1 who had directly observed you. The panel therefore afforded the contemporaneous evidence significant weight and found it to be consistent with Witness 1's oral evidence. The panel therefore finds this charge proved.

Charge 5f(i)

f) On 11 November 2022:
   i. Did not clean the trolley containing equipment needed to connect patients to dialysis machines.

These charges are found proved.

In reaching this decision the panel took account of all the relevant evidence.

Witness 1's witness statement included:

> *'I had to keep reminding Ms Wright to clean the silver trolley, as she would only clean the top of it, and she would leave the used cleaning wipes at the bottom of the trolley. These wipes need to go straight into the waste clinical bin.'*

Witness 1 also mentions in the Observation notes dated 11 November 2022 that she always needed to remind you to clean your silver trolley properly as it was noted that you only cleaned the top of it and leaving the used wipes on the bottom of the silver trolley.

Patient 2's witness statement included:

> *'I also noticed that on this day and on other days, Ms Wright would not clean the silver trolley. This trolley has a metal tray on the top which has the equipment needed to connect patients to the dialysis machine. After each patient, the nurses usually wipe down the trolley vigorously. In between patients I noticed that Ms Wright would not clean the trolley or wash her hands.'*

The panel preferred the evidence of Witness 1 and Patient 2. It determined that these were contemporaneous accounts by people who directly observed you on the day in question.

The panel was of the view that on the basis of the corroborative evidence of Witness 1 and Patient 2, supported by contemporaneous accounts, these charges are found proved.

Charges 5f(ii), 5f(iii)

ii. Did not wash/disinfect your hands between patients and/or cleaning equipment.
iii. Failed to change gloves.

These charges are found proved.

In reaching this decision the panel took account of all the relevant evidence.

The panel noted the report from Patient 2, notably

> *'12:46 – Penny has now moved onto seeing to my needs. As she starts, she clearly has not wiped down the table...neither has she washed her hands.* [Witness 1] *had to remind her of infection control. She went straight from doing Patient 3's care to mine'.*

The panel also had regard to the local Observation notes of 11 November 2022:

> *'needs to stop her to disinfect her hands and changed her gloves as she's picked something on the floor and she wants to continue to use that particular glove with the patients connection of his blood lines and needle.'*

In the same notes she records:

> *'not washing her* [Ms Wright] *hands properly'*

and

‘when cleaning machine always to remind her to change her gloves to new gloves. As she always wants to use the same gloves that she used taking off the patients’

You refuted any suggestion that you did not wash or clean your hands between patients or change your gloves. You stated that you did change your gloves when going between patients and / or equipment. You said that you always adhered to the five moments of hand hygiene.

The panel gave considerable weight to the contemporaneous accounts of Patient 2 and Witness 1 and accordingly preferred their evidence to your evidence which was effectively a bare denial. The panel therefore finds this charge proved.

Charge 5f(iv)

iv. Did not clean up blood left on the floor/bed from previous patient/s.

This charge is found proved.

In reaching this decision the panel took account of all the relevant evidence.

The panel noted Witness 2’s contemporaneous report:

‘12:15pm: on entering the unit (as I walked through the door); [Witness 1] *pointed out that Penny had left blood on the floor under and around the bed opposite to mine’.*

The panel noted that he further went on to say that this was not an isolated incident and similar had happened on multiple occasions when you were in attendance in bay 1. Patient 2 gave a clear account in oral evidence of remembering this incident.

The panel also had regard to the Observation notes of 11 November 2022 where it is recorded:

‘Blood splashed found on the floor’

You contended that both witnesses were wrong and that the blood that was seen that day was a *“minuscule”* amount on a bed rail. The panel considered this explanation but was not persuaded and found that both Patient 2 and Witness 1 were evidently referring to a larger amount of blood being present.

The panel preferred the evidence of Witness 1 and Patient 2 in the light of the contemporaneous recording of this incident and the degree to which the accounts corroborate each other. The panel therefore find this charge proved.

Charge 5g(i), 5g(ii)

g) On 14 November 2022:
   i. Were unaware that a dialysis machine was not priming.
   ii. Did not identify that an unknown patient’s arterial line was not connected properly to the dialysis machine.

These charges are found proved.

In reaching this decision the panel took account of all the relevant evidence.

The panel had regard to the Observation notes dated 14 November 2022. Witness 1 records that she was observing you on this day and you were unaware that a dialysis machine was not priming. You had also not noticed that the machine was not priming and the arterial line was not connected.

Witness 1’s witness statement included:

‘Ms Wright did not notice that a dialysis machine was not priming. The circuit needs to be prime with at least 500 mis of dialysis fluids or more before the patients are connected to the machine. The patient's machine was not running as

the machine stated it was wet. This meant that the machine safety line was loosely connected, and this needed to be resolved before the machine could be primed. Ms Wright said to me that she did not know why her machine was leaking. I looked at the machine and noticed that the arterial line was not connected properly. I noted on other times that Ms Wright did not notice that her machine was not priming, as the door of the machine was not properly closed. This is another reason why Ms Wright would be delayed in connecting patients to the dialysis machines, as you need to wait for the machine to prime.'

The panel noted that during your oral evidence that you do not recall this event or the day in question.

The panel afforded significant weight to the contemporaneous evidence provided, given you have no recollection of these incidents happening. The panel found Witness 1 to be a credible, reliable and consistent witness. The panel therefore finds these charges proved.

Charge 5g(iii)

iii. In respect of Patient 11;
(1) Struggled to insert their needle.
(2) Were unable to calculate their UFgoal.

These charges are found proved.

In reaching this decision the panel took account of all the relevant evidence.

The panel had regard to the Observation notes dated 14 November 2022. Where Witness 1 records that you attended Patient 11 and were still struggling to needle the patient. The panel had regard to evidence of you not being able to calculate the UFgoal.

Witness 1's written statement included:

‘Ms Wright was struggling to insert the needle into Patient 11. Patient 11 had a big number of fluids to be taken off of him that day through dialysis. Ms Wright did not investigate as to why this was. I asked Ms Wright if she weighed the patient with her cardigan on and Ms Wright said she did. I weighed the cardigan,and it weighed nearly 1kg. Ms Wright included the weight of the cardigan as part of the UFGOAL, so this gave an inaccurate reading of fluids to be drained. If too much fluid is drained, this can cause harm to the patients as it can cause hypotension or cramps, so it is important that patients are properly weighed and assessed properly at the start of dialysis’.

Your oral evidence was that you disagreed with this evidence.

The panel afforded significant weight to the contemporaneous evidence provided, given you have no recollection of these incidents happening. The panel found Witness 1 to be a credible, reliable and consistent witness. The panel therefore finds these charges proved.

Charges 5g(iv) and 5g(v)

iv. In respect of Patient 10 wrongly identified that they required their Diafer medication to be administered.
v. In respect Patient 13 did not read their prescription to identify the correct needle size for them.

These charges are found proved.

In reaching this decision the panel took account of all the relevant evidence.

The panel had regard to the Observation notes dated 14 November 2022 in which Witness 1 records you using the wrong needle size. Witness 1 wrote that you do not read the prescription properly. She asked you to read and check what the needle size was and identified that you were using the wrong needle.

The panel took account of Witness 1’s witness statement, which included:

'Ms Wright informed me that Patient 10 required his Diafer medication. I reviewed the patient's prescription and noticed it is prescribed monthly, with the last medication administered on 31 October 2022. I explained it was too early and we needed to follow the dates on the prescription'.

Further, Witness 1 recorded in her Observations of 14 November 2022:

'[Patient] *13-wrong needle size as she doesn't read the prescription properly, so when I asked her again to read she says it's wright 15 GA, but I said look on again she said, so it [sic] wrong he needs longer needle. I told her not long it means 15 Ga, and 20 length, not long.'*

Your evidence was that you had no recollection of these events, that you do not recall this happening and do not agree that this took place. You said that you did not think you would have forgotten about Diafer. The panel considered these to be vague denials.

The panel afforded significant weight to the contemporaneous evidence provided, given you have no recollection of these incidents happening. The panel found Witness 1 to be a credible, reliable and consistent witness. The panel therefore finds these charges proved.

Charge 5h(i)

h) On one or more occasion on dates set out in Schedule A:
   i. Failed to dispose of clinical waste appropriately.

This charge is found proved.

In reaching this decision the panel took account of all the relevant evidence before it.

In the Observation notes dated 11 November 2022, Witness 1 records that you were still not disposing of waste correctly, had found an apron and used gloves in the mixed

recycling bin and that after your work the floor was really untidy with lots of rubbish on the floor and gauze with bloods and used wipes placed in the recycle bin.

In the Observation notes dated 14 November 2022, Witness 1 records that regarding your cleaning, you were having a lot of issues with the disposal of used wipes and gauze with blood on it, as instead of you dropping them into your small yellow bag provided to you for this purpose you just throw them on the bottom shelf of the silver trolley and sometimes they would land on the floor.

In the Observation notes dated 15 November 2022, Witness 1 records you leaving lots of gauze with blood stains on the floor and dropping used needles on the floor twice.

The panel gave weight to the contemporary documentation which it determined support this charge and was consistent with other failings. The panel noted that this issue was observed and recorded on numerous other dates that fall outside the dates within Schedule A. As such, the panel was of the view that poor waste management was a longstanding failure of your practice and these were not new or isolated events.

The panel considered that a failure arises where there is a duty as a registered nurse to do a task in an appropriate manner in line with a policy of the standard required of a registered nurse. The panel determined that you had breached not only the Waste Separation policy but also basic nursing standards of waste management.

The panel found repeated strong contemporaneous evidence and it afforded this significant weight. The panel determined that you are more likely than not failed in your duty in this regard. The panel therefore finds this charge proved.

Charge 5h(ii)

ii. Failed to dispose of sharps in sharps bins.

This charge is found NOT proved.

In reaching this decision, the panel took into account all the relevant evidence.

The panel considered the Observation notes dated 15 November 2022. The panel was of the view that there was a degree of confusion in the evidence of Witness 1 and Witness 3 as to whether this referred to needles or syringes. The panel noted that there is only mention of needles in the Schedule and one reference from Witness 1 to needles being dropped on the floor. It is unclear, however, whether this was accidental and whether they were eventually placed in the sharps bin.

Given the lack of specificity in the evidence in relation to the wording of the charge, the panel did not consider that the NMC had discharged its burden of proof. Accordingly the panel found this sub-charge not proved.

Charge 5h(iii)

iii. Failed to use a new wipe to clean separate surfaces.

This charge is found proved

In reaching this decision the panel took account of all the relevant evidence.

The Observation notes dated 14 November 2022 recorded by Witness 1 report:

> *'cleaning station still got lots of issues as PW gets a bunch of wipes wet it and used to clean the table, bed and machine with the same wipes, so again I did stop her doing this and explained the importance of using different wipes on bed, chair and table'.*

The Observation notes dating 15 November 2022 which record:

> '*6. Still cleaning machine, bed and table...Penny uses same wipes in bed, chair, tables and in other stations.'*

You evidence was an outright denial. You said that you would have used a clean wipe.

The panel preferred the evidence of Witness 1 supported by the contemporaneous evidence to your denial.

The panel had regard to the NephroCare Hygiene Standard and Infection Control Policy and the NephroCare Hygiene Plan Policy. The panel determined that it was your duty to use a new wipe to clean different surfaces in order to maintain good infection control and you failed in that duty. The panel therefore finds this charge proved.

Charge 5h(iv) and 5h(v)

iv. Failed to clean your hands effectively.
v. Did not adhere to the 5 moments of hand hygiene

These charges are found proved.

In reaching this decision the panel took account of all the relevant evidence.

The panel noted that the failure to clean your hands effectively is mentioned in all three of the Observation notes dated 11, 14 and 15 November 2022.

Patient 2 in his local complaint letter states that :

'..she clearly has not wiped down the table to which she prepared my needles/Saline etc neither has she washed her hands...'

Patient 7 in her complaint letter includes:

'She's very clumsy as to dropping sterile items on the floor then picking up and putting on a sterile table, forgetting to wash her hands.'

The panel also noted your contention that you always cleaned your hands when required and adhered to the *'five moments of hand hygiene'*, however the panel reminded itself of its earlier findings that you had not.

The panel had regard to the NephroCare Hygiene Standard and Infection Control Policy and the NephroCare Hygiene Plan Policy. The panel determined that it was your duty to clean your hands effectively and adhere to the '*five moments of hand hygiene'* in infection prevention at all times.

The panel afforded significant weight to the contemporaneous Observation notes which were corroborated by the observations of two patients. The panel therefore finds this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether those facts it found proved amount to a lack of competence 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 safely, kindly 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 a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence.

Submissions on lack of competence

The NMC Lack of Competence Guidance FTP-2b states:

> *'Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.'*

You gave evidence under oath on impairment.

You were asked and answered a series of question from Mr Finnegan.

You told the panel that in the intervening period since being dismissed by Clinic 2 in December 2022, you have been looking for employment in your field of nursing practice, however while the interviews went very well, you were unsuccessful due to the current interim conditions on your practice and the workload it involved for the prospective employer. You said that you have also been reading and doing some research.

Mr Finnegan took you to the training certificates you provided, namely: Safe Handling Administration of Medication dated 14 March 2023; Confidentiality dated 13 March 2023 and Good Record-Keeping dated 12 March 2023. In response to what you have learned from these courses, you said it had been to make sure patients get the best care that you can give them.

In relation to your Reflective Notes dated 9 October 2025, you said you reflected on where things went wrong, what you would do differently and what the best approach to take to ensure that things like medication errors do not happen again.

In response to the question whether you are currently impaired, you said you do not believe you are and asked to be specifically pointed to where and how your practice is impaired.

In response to panel questions in relation to consideration of other forms of employment since 2022, such as working as an HCA or doing voluntary work, you said that you have not pursued them but could do in the future. You were asked whether there was anything you had learned about yourself or your practice. You said that it was about integrity, being aware of things, why did it happen and what you could do to improve your practice even more. You were asked about the duration of validity of the training course 2023 certificates provided. You said you think the majority of them are valid for twelve months. You believed these were online courses.

Ms Fergus-Simms referred the panel to the legal authority in the case of *Calhaem v GMC* [2007] EWHC 2606 (Admin) and the NMC Lack of Competence Guidance FTP-2b. She submitted that lack of competency needs to be assessed using a three stage process:

- *Is there evidence that you were made aware of the issues around your competence?*
- *Is there evidence that you were given the opportunity to improve?*
- *Is there evidence of further assessment?*

She submitted that you were aware of issues surrounding your competence as early as July 2021 when you were employed at Clinic 1. She submitted that these longstanding issues were addressed at Clinic 2, therefore under two separate clinical units.

Ms Fergus-Simms referred the panel to ***'****The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 2015* (as amended) ("the Code")'. She identified the following specific, relevant standards where in the NMC's view, your actions amounted to a breach of those standards: 2.4, 2.5, 2.6, 4.1, 6.2, 8.1, 8.2, 8.3, 8.4, 8.5, 8.6, 8.7, 10.1, 10.2, 10.3, 10.4, 10.5, 10.6, 13.1, 13.4, 14.1, 14.2,14.4, 19.1, 19.2, 19.3, 19.4, 20.1, 20.2, 20.3, 20.5 and 20.6.

She invited the panel to take the view that the facts found proved amount to a lack of competence.

Mr Finnegan submitted that, having taken further instructions from you, your position remains broadly the same as it was throughout the hearing, that the evidence heard and the facts found proved, do not amount to a lack of competence.

Submissions on impairment

Ms Fergus-Simms then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). She referred the panel to the guidance formulated by Dame Janet Smith in her *Fifth Shipman Report*:

> *'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. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

Ms Fergus-Simms referred the panel to the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin). She submitted that limbs a, b and c of the test in *Grant* are satisfied in this case as to your past and future practice.

Ms Fergus-Simms referred to the following factors set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin):

- Is the behaviour easily remediable?
- Has it already been remedied?
- Is it highly unlikely to be repeated?

She submitted that the panel should take into account that your lack of competence does not relate to an isolated incident and involves repeated and similar shortcomings over a wide-ranging set of basic nursing skills. She submitted that, when fairly taking into account all of the relevant factors and information before the panel at this stage, the NMC submits that there is no evidence before it of any steps taken towards remediating your lack of competence, and accordingly the panel may decide that you have not remediated and therefore as a consequence there is a likelihood of repetition.

She submitted that it is clear that patients were put at risk of harm. She referred in particular to Patient 2 with regards to your failure to aspirate the bubbles within the syringe and Patient 7 with regards to pulling the neckline. She submitted whether there is a risk of damage to the reputation of the nursing profession due to your lack of candour and attempts to accuse colleagues of collusion and fabrication and whether therefore your integrity is in question in terms of transparency over any future mistake should a future error take place, is a matter for the panel.

In relation to insight, Ms Fergus-Simms submitted that the panel may well have concerns about your lack of insight into the areas of concern. She submitted that throughout these proceedings, even when concessions have been made by you, you have sought to shift the blame, for example, onto Witness 1 and HCA colleagues. Further, you maligned the characters of colleagues, disputing in these proceedings the veracity of their statements and documentation, such as records of disciplinary hearings, that documented your employment with the Company.

Ms Fergus-Simms submitted that the panel may wish to also take into consideration your attitudinal issues identified in this case, noting that some of the charges found proved relate to your failure to carry out proper instructions. She submitted that this attitudinal problem has emerged through your evidence towards Witness 1 or anyone who seeks to correct you. She submitted that it is difficult to know how you could work safely, even under direction with this attitude. She submitted that duty of candour is

central to the role of a nurse and the trust that vulnerable patients place in you. She submitted that without a very serious change in attitude it is hard to see how you will address your current impairment.

She referred the panel to the NMC guidance DMA-1 on impairment. Which includes 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?"*

Ms Fergus-Simms submitted that the facts found proved show that your competence and performance at the material times was below the standard expected of a registered nurse. She submitted that the preponderance of all the evidence heard and the facts found proved show that you are not able practice safely, kindly and professionally.

In relation to public interest, Ms Fergus-Simms submitted that public confidence in the profession would be undermined if a finding of impairment were not made in light of the number of clinical areas the panel found to be to be unsafe in terms of your practice.

Ms Fergus-Simms invited the panel to make a finding of impairment on the ground of public protection and also in the wider public interest.

Mr Finnegan submitted that it is your position that you are not currently impaired.

Mr Finnegan asked that the panel give you a wide margin to make your case that the patient complaints were procured through coercion and that much of the evidence from the NMC coming from the witnesses was to a large extent fabricated and / or misremembered.

He submitted that despite the findings of fact the panel have made, these events occurred in an environment where you were under a considerable degree of pressure and [PRIVATE], and from time to time you were being distracted. He submitted that it provides strong mitigation such that none of them either individually or taken together

the panel could safely come to a conclusion that a lack of competence has been exhibited.

Mr Finnegan submitted that you have practised as a dialysis nurse for approximately 30 years with no issues of any description on your practice or character. He referred the panel to the training certificates that you have undertaken which shows an intention to strengthen your practice. He submitted that a significant constraint to your further developing your practice has been the interim conditions imposed on your practice that has caused you some difficulty in finding a job as a nurse in the intervening period.

Mr Finnegan submitted that, in relation to the point raised by Ms Fergus-Simms that you have an attitudinal problem as related to current impairment, he asked that the panel resile from finding that you exhibit attitudinal issues. He submitted that you were simply putting your case forward in a respectful manner and the points were fairly put.

In conclusion, Mr Finnegan submitted that there has been no breach of the Code and based on the evidence there has not been a lack of competence and therefore you are not currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Amao v NMC* [2014] EWHC 147 (Admin); *Cohen v GMC* [2008] EWHC 581 (Admin) and *Grant.*

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code and identified sections of it, where in the panel's view amounted to a breach. The panel bore in mind that there was no burden or standard of proof at this stage. The panel had to reach its decision on lack of competence having regard to its own professional judgement.

The panel bore in mind that this case did not involve misconduct but determined that there had been departures from the Code. The panel determined that you did not:

‘1 Treat people as individuals and uphold their dignity

2 Listen to people and respond to their preferences and concerns

6 Always practise in line with the best available evidence

8 Work co-operatively and respect the skills, expertise
8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
8.5 work with colleagues to preserve the safety of those receiving care

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues
9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times;

10 Keep clear and accurate records relevant to your practice

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 regulation

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’

The panel bore in mind, when reaching its decision, that you should be judged by the standards of a reasonable average registered nurse and not by any higher or more demanding standard.

In considering whether you had shown a lack of competence, the panel bore in mind that this would usually involve finding that there had been an unacceptably low standard of professional performance, judged on a fair sample of work, which could put patients at risk. The panel found in its previous findings, that you had shown a lack of knowledge, skill or judgement demonstrating that you were not capable of safe and effective practice. The panel noted that you had shown a pattern of incompetence at two clinics over a period of over a year. Your errors involved basic nursing skills.

In all the circumstances, the panel determined the facts found proved demonstrated a lack of competence.

Decision and reasons on impairment

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

In this regard the panel considered the *"test"* of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 76, she said:

> *'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*

The panel found that vulnerable patients were put at risk of serious harm as a result of your lack of competence. The panel had already accepted the evidence of Witness 1 who commented on how unsafe your practice was and how she was required to intervene to prevent patient harm.

The panel had regard to the complaints received from the patients. In their local complaint submitted to Clinic 2, Patient 4 referred to you:

> '*Causing mental health problems in patients because 3 of us in our bay panicked if we thought we might have* [you] *and even worried about it the night before and didn't want to go to dialysis*'

Patient 2, in his complaint of 14 November 2022 referred to *'Grave concerns with regard to* [your] *professional ability'* and stated:

> '*I believe that this feedback is critical as someone's life may well be in danger should these issues not be addressed as soon as possible...Something needs to be done because it's only a matter of time that someone less observant could have serious repercussions having been at the mercy of what can only be described as perilous care from* [you]*'*

Patient 7, in her complaint to Clinic 2 in November 2022, stated:

> *'I feel she is a danger to patients and herself... She is looking after vuneral* [sic] */sick people, our lives are in her hands and they are not safe'*

The panel determined that there has been little evidence put before it to demonstrate any relevant learning or strengthening of practice, therefore there is at present a risk to patients of unwarranted harm.

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

The panel determined that your lack of competence had brought the nursing profession into disrepute. The panel had particular regard to the patients who had referred to concerns that they would not wish to attend dialysis if you were their nurse and expressed genuine concerns for their safety. The panel also took account of Patient 4 and Patient 7's accounts of you being rude and / or disrespectful towards your

supervisor. The panel determined that informed members of the public would be extremely concerned about your practice and without it having been remediated would in the future bring the nursing profession into disrepute.

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*

Your lack of competence had breached the fundamental tenets of the nursing profession namely: prioritise people; practise effectively; preserve safety and promote professionalism and trust. The panel determined that by your actions, you did not treat patients with professionalism or deliver safe care to numerous patients in a number of settings. In light of your lack of insight, reflection and remorse the panel determined that you are liable to do the same in the future.

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

In light of the fact there was no charge of dishonesty, the panel did not consider it appropriate to make a finding of dishonesty based upon the way this case has been conducted.

The panel considered the factors set out in *Cohen* / NMC guidance DMA-1*:*

- Is the behaviour easily remediable?

The panel was of the view that you underwent extensive one-to-one supervision, induction programmes and were set clear achievable objectives. Yet you could not achieve the standards set in those objectives and did not avail yourself of the relevant policies provided to you.

The panel considered your ability to work under supervision. It had sight of evidence from Ms 1 and heard oral evidence from Witness 1 and Witness 3 indicating that you have attitudinal issues. The panel was concerned whether you could or would want to

change your attitudinal issues. The panel was not persuaded that your attitudinal issues are currently remediable in your case.

- Has it already been remedied?

The panel considered whether there is a risk of repetition and in doing so assessed your current insight, remorse and remediation. The panel had sight of the three training certificates you provided at this stage. It noted that none were current and they dated back to 2023. Further the panel was aware that they were online courses and their value compared to attending a physical course was difficult to quantify. It noted one certificate's subject was confidentiality which has no obvious relevance to the regulatory concerns in your case.

The panel had sight of your reflective note dated 9 October 2025 and noted that you had not taken the opportunity to update it in light of the panels finding on facts. Your reflection related solely to one medication error and did not cover any of the wider issues relating to your competence. Whilst it did include some insight on patients and colleagues it did not include any reflection on the impact of your performance on the nursing profession as a whole.

In its consideration of whether you have taken steps to strengthen your practice, the panel recognised that you have not been working as a nurse as a result, you submit, of the interim conditions of practice order in place. The panel took into account that you have not sought alternative employment, for example as an HCA or in any allied profession, in order to demonstrate strengthened practice. The panel had particular regard to the fact that when you were in practice you were not able to engage with the local support provided to you and rejected it and at other times found the support obstructive, blaming others and perceiving it as unnecessary and punitive. The panel determined that you had shown a pattern of incompetence across both clinical practice and fundamental nursing skills.

While the panel acknowledge that holding patients' hands, relieving stress etc mentioned by you as part of your patient care and nursing practice, it was of the view that these are interpersonal skills of kindness any nurse should have.

- Is it highly unlikely to be repeated?

The panel was of the view that there is a risk of repetition in the future. You have not shown progress, or taken steps to gain suitable alternative employment. The panel determined that you continue to present a significant risk in future of similar conduct. You have shown no remorse for your actions and behaviour and continue to deny the charges and deflect blame. Furthermore you have provided only one testimonial and no reference from any previous employer. You have provided the panel with no up-to-date training and continued to demonstrate a lack of knowledge of policies and lack of insight for the concerns raised.

The panel was of the view that while there had been no reported prior incidents in relation to your practice in the past it further noted the deterioration in your practice between February and July 2021 at Clinic 1. The panel was aware of repeated offers of external assistance which you rejected.

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.'*

In this case, the panel could not answer affirmatively. The panel was of the view that above all, people expect a nurse to be able to practise kindly, safely and professionally at all times. The panel determined that this is absolutely necessary in order to uphold standards of conduct and performance of a professional nurse. Taking into account the

reasons given by the panel for its findings of the facts, the panel has concluded that you lacked the skill and judgement to practise safely and you had not acted professionally at all times. It therefore decided that you are not able to practise kindly, safely and professionally.

The panel therefore concluded that a finding of impairment is necessary on the ground of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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, in this case, a finding of impairment on public interest grounds was required. The panel determined that informed members of the public would be extremely concerned about your practice and that on current evidence is not remediated. The panel also considered the view the public have on dialysis as a bedrock life-saving function of these patients' care, where they would spend a significant amount of time attending the clinics over a substantial period of years.

The panel concluded that public confidence in the profession would be undermined if a finding of current impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months with review. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Submissions on sanction

The panel was aware that in the Notice of Hearing dated 12 September 2025, the NMC had advised you that it would seek the imposition of a conditions of practice order for a period of 18 months if it found your fitness to practise currently impaired. Ms Fergus-Simms in her submission confirmed that the NMC seek the imposition of a conditions of practice order for a period of 18 months with review.

Ms Fergus-Simms took the panel through the factors in the SG where conditions of practice are appropriate. However, she submitted that it is ultimately a matter for the panel to determine whether it would be possible in this case to formulate relevant, appropriate and workable conditions which would address your lack competence. In particular whether you have the ability and willingness to comply with any conditions of practice, in view of your attitude to colleagues who seek to address and guide you and your attitude to deflecting blame. She submitted that patients have been put at risk to the extent that some have refused to be cared for you. She submitted that to date, you have not adequately reflected and during the course of this hearing have continued to deflect blame.

Ms Fergus-Simms submitted that as the panel has noted and it is of grave concern, that you continue to make basic nursing errors, and this was apparent to the panel even during the course of your own evidence. She submitted that your attitude will of course be of concern to anyone tasked with supervising you given the close scrutiny that will be needed to prevent mistakes and keep patients safe, even on routine basic nursing procedures.

Ms Fergus-Simms submitted that neither taking no action nor imposing a caution order would be appropriate due to your proved widespread lack of competence and the need to protect the public from harm, including the damage which has been done to the

nursing profession in the light of the patients' grave concerns for your ability to care for them.

Ms Fergus-Simms outlined the conditions of practice proposed by the NMC and provided the panel with a document containing the details of fifteen conditions which, in the NMC's view, are applicable in your case.

The panel also bore in mind Mr Finnegan's submissions that he accepts the proposed conditions of practice suggested by Ms Fergus-Simms. He submitted that a conditions of practice order for a period of 18 months would be proportionate and also strikes a fair balance between your rights and the need to protect the public.

Mr Finnegan then addressed the panel on a suspension order which he accepted is potentially a sanction open to the panel to make. He asked the panel to take account of the fact that an interim conditions of practice order has been in place on your practice for quite some time which has had the effect of being tantamount to a suspension. He submitted that this has constrained you seeking other employment and had a serious impact on your ability to find employment as a nurse.

Mr Finnegan asked the panel to give consideration to the delay in these proceedings and that an appropriate reduction in sanction be imposed that might otherwise have been the case. He referred the panel to the case of *Okeke v NMC* [2013] EWHC 714 (Admin) on this point, on whether it is appropriate to make a reduction in the length of any sanction which would otherwise have been imposed.

He referred to the attitudinal issues referred in this case. He submitted that the deployment of a robust defence is your right and should not be construed as an attitudinal issue, a refusal to remediate or a ground for increasing a sanction.

In reference to the overarching objectives of protecting the public, of maintaining public confidence and maintaining and promoting the proper standards of competence, he submitted that this must be considered against your thirty years of unblemished nursing practice, with only two of those years being spent in a quasi-nursing or clinical role.

Referring to the complaints made by Witness 1 and Witness 3, he submitted that we have not heard from other nurses who have worked with you over the years who have no critique of your competence as well as from many hundreds of patients you have cared from who similarly have no complaints.

Mr Finnegan submitted that it serves no good purpose to suspend you from practice taking all the issues in your case into consideration and the findings of the panel. He submitted that some the charges are of a more minor nature and some of them are of a rather more serious nature. He asked the panel to bear in mind your admissions at an early stage of this hearing to two of the more serious charges. He submitted that a suspension order would risk crossing the line from an appropriate sanction and a punishment or punitive order.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Attitudinal issues, not in regard to how you have conducted your defence, but in regard to your lack of respect shown to your supervisors and colleagues during your employment
- A failure to properly engage with the support made available to you, including mentors and supervisors
- A continued pattern of incompetence involving clinical errors over an extended period of time, in two separate locations involving failures to apply fundamental nursing skills despite significant one-to-one support

- Breaches of basic nursing standards which put vulnerable patients at risk of suffering serious harm which they recognised and was sufficiently concerning that they refused to be treated by you
- You have demonstrated a lack of insight into your actions and omissions and the impact they had on patients, colleagues and the reputation of the profession.

The panel also took into account the following mitigating feature:

- You made admissions to two charges at this hearing;

In terms of personal mitigation, the panel considered that you said that you were [PRIVATE] at the material times. However, the panel noted that you were offered external help but refused the support offered to you and had failed to engage with the support of mentors and an educational lead nurse. It therefore determined that this did not amount to a mitigating factor. The panel noted your longstanding practice of 30 years as a dialysis nurse without incident, however the panel considered that every nurse is expected to be clear of regulatory concerns, and therefore this was not a mitigation.

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 nor would it protect the public.

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, it would be inappropriate given the risk of harm to patients. The panel was of the view that due to the overall level of incompetence over an extended period it was within the public interest that such a nurse is not able to practise independently. It therefore determined that 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 lack of competence 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. It bore in mind the detailed conditions proposed by the NMC. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, which sets out that a conditions of practice order may be appropriate when some of the following factors are apparent:

- *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 is of the view that there are no practical or workable conditions of practice that could be formulated given the nature of the charges found proved in this case, the wide range of failures in fundamental nursing practice, the number of patients involved and the period of time over which your failings occurred. Whilst there were identifiable areas that could potentially be addressed through retraining, the panel noted that the issues covered in the proposed conditions of practice order effectively mirror those issues which were not previously addressed by you in your action plan, informal PIP and formal PIP.

The panel determined that you have made no significant steps to address the concerns

identified with your practice. It heard evidence that you did not work well with support and perceived it as an injustice to you. The panel was concerned that you would go against another supporting nurse thereby not complying with conditions. Unless there is a change in your attitude conditions would remain unworkable.

Your attitude was found to be an aggravating factor in the panel's deliberations in terms of your interactions with mentors and supervisors. The panel noted that even when working under supernumerary conditions you were not able to work with one-to-one supervision. When you had worked on a supernumerary basis, moreover, your practice did not reach a sufficiently high standard to reach the objectives in your improvement plans. Therefore a reduction in the supervisory regime as proposed by the NMC is contrary to the evidence before the panel. Moreover, it would be unrealistic to expect an employer to hire someone in solely a supernumerary capacity.

The panel noted that in effect, you have been on interim conditions of practice and was still unable to practise safely. The panel noted that in effect you have been on interim conditions of practice and were still unable to practise safely. The panel doubted that you would comply with conditions or respond positively to the necessary supervision. Therefore a conditions of practice order is not workable and would not protect the public.

The panel reminded itself of the patients who complained and felt they were in danger from being cared for by you. The panel was of the view that you were practicing dangerously in doing technical and invasive procedures with vulnerable patients. In light of your general incompetence in a large number of practical and clinical skills, the panel did not consider that the public would be adequately protected with a conditions of practice order given that you would not be supervised at all times.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel considered the SG on when suspension orders are appropriate and in particular took into account this factor:

- *In cases where the only issue relates to your lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

In making this decision, the panel carefully considered the submissions of Ms Fergus-Simms in relation to the sanction that the NMC was seeking in this case. However, the panel had regard to the danger and risk to vulnerable patients and determined that the number of instances of your general incompetence regarding wide-ranging basic skills and specialist renal nurse skills put patients at serious risk of harm.

The panel was of the view that a suspension order would give you time to focus on the development of your practice whilst undergoing some retraining. This could be achieved by voluntary or paid employment as a HCA or in some other allied health profession, and its successful completion would provide you with retraining opportunities and potentially positive testimonials and references of your practice. A period of suspension would also give you time to come to terms with the decision of this panel and reflect upon it.

The panel determined that it would be appropriate to impose a sanction of a suspension order 12 months duration, in order that you should be provided with sufficient time to reflect and focus on the steps that you must take to return to nursing.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of competence required of a registered nurse. Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction in this case.

This would mark the seriousness of your lack of competence and allow you sufficient time to address your failings, strengthen your practice and then provide evidence of this either by courses you have taken or testimonials from employers in paid and / or voluntary work.

The panel did not go on to consider whether to impose a striking off order as this sanction is not available at this time.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case may be assisted by:

- Reflection and insight covering the wide-ranging failures identified in your practice from the very basics of nursing care through to the specialist care required of a renal nurse
- Evidence of employment whether in a clinical setting or not
- Documentary evidence of completion of relevant courses that strengthen your practice including for example: understanding policies and procedures, medication management, waste management, teamwork, duty of candour, reflective practice, record keeping, infection control
- Testimonials and references from your employer or voluntary establishment that detail your current work practices, particularly your approach to service users

This will be confirmed to you in writing.

Interim order

As the suspension 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 interest until the suspension order sanction takes effect.

Submissions on interim order

The panel considered the submissions made by Ms Fergus-Simms that an interim suspension order should be made to cover the appeal period. She submitted that an interim order is necessary for the protection of the public and to protect the wider public interest. Ms Fergus-Simms invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period if any appeal is made.

Mr Finnegan opposed the application.

He submitted that the interim conditions of practice order that you have adhered to is tantamount to a suspension, therefore there is no need for the interim suspension order to be imposed.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of your lack of competence and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. The panel considered that to not impose an interim suspension order would be inconsistent with its earlier findings.

The panel made an interim suspension order for a period of 18 months.

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

That concludes this determination.